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NEWS 1 Web Page URLs for STN Seminar Schedule - N. America
NEWS 2 "Ask CAS" for self-help around the clock
NEWS 3 DEC 21 IPC search and display fields enhanced in CA/CAplus with the
IPC reform
NEWS 4 DEC 23 New IPC8 SEARCH, DISPLAY, and SELECT fields in USPATFULL/
USPAT2
NEWS 5 JAN 13 IPC 8 searching in IFIPAT, IFIUDB, and IFICDB
NEWS 6 JAN 13 New IPC 8 SEARCH, DISPLAY, and SELECT enhancements added to
INPADOC
NEWS 7 JAN 17 Pre-1988 INPI data added to MARPAT
NEWS 8 JAN 17 IPC 8 in the WPI family of databases including WPIFV
NEWS 9 JAN 30 Saved answer limit increased
NEWS 10 JAN 31 Monthly current-awareness alert (SDI) frequency
added to TULSA
NEWS 11 FEB 21 STN AnaVist, Version 1.1, lets you share your STN AnaVist
visualization results
NEWS 12 FEB 22 Status of current WO (PCT) information on STN
NEWS 13 FEB 22 The IPC thesaurus added to additional patent databases on STN
NEWS 14 FEB 22 Updates in EPFULL; IPC 8 enhancements added
NEWS 15 FEB 27 New STN AnaVist pricing effective March 1, 2006
NEWS 16 FEB 28 MEDLINE/LMEDLINE reload improves functionality
NEWS 17 FEB 28 TOXCENTER reloaded with enhancements
NEWS 18 FEB 28 REGISTRY/ZREGISTRY enhanced with more experimental spectral
property data
NEWS 19 MAR 01 INSPEC reloaded and enhanced
NEWS 20 MAR 03 Updates in PATDPA; addition of IPC 8 data without attributes
NEWS 21 MAR 08 X.25 communication option no longer available after June 2006
NEWS 22 MAR 22 EMBASE is now updated on a daily basis
NEWS 23 APR 03 New IPC 8 fields and IPC thesaurus added to PATDPAFULL
NEWS 24 APR 03 Bibliographic data updates resume; new IPC 8 fields and IPC
thesaurus added in PCTFULL
NEWS 25 APR 04 STN AnaVist \$500 visualization usage credit offered

NEWS EXPRESS FEBRUARY 15 CURRENT VERSION FOR WINDOWS IS V8.01a,
CURRENT MACINTOSH VERSION IS V6.0c(ENG) AND V6.0Jc(JP),
AND CURRENT DISCOVER FILE IS DATED 19 DECEMBER 2005.
V8.0 AND V8.01 USERS CAN OBTAIN THE UPGRADE TO V8.01a AT
<http://download.cas.org/express/v8.0-Discover/>

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* * * * * STN Columbus * * * * *

FILE 'HOME' ENTERED AT 12:37:18 ON 05 APR 2006

=> file reg

COST IN U.S. DOLLARS

SINCE FILE

TOTAL

ENTRY

SESSION

FULL ESTIMATED COST

0.21

0.21

FILE 'REGISTRY' ENTERED AT 12:37:25 ON 05 APR 2006

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STRUCTURE FILE UPDATES: 3 APR 2006 HIGHEST RN 879121-98-9

DICTIONARY FILE UPDATES: 3 APR 2006 HIGHEST RN 879121-98-9

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TSCA INFORMATION NOW CURRENT THROUGH January 6, 2006

Please note that search-term pricing does apply when conducting SmartSELECT searches.

*
* The CA roles and document type information have been removed from *
* the IDE default display format and the ED field has been added, *
* effective March 20, 2005. A new display format, IDERL, is now *
* available and contains the CA role and document type information. *
*

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<http://www.cas.org/ONLINE/UG/regprops.html>

=> file caplus medline biosis embase

COST IN U.S. DOLLARS

SINCE FILE

TOTAL

ENTRY

SESSION

FULL ESTIMATED COST

0.44

0.65

FILE 'CAPLUS' ENTERED AT 12:37:38 ON 05 APR 2006

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FILE 'BIOSIS' ENTERED AT 12:37:38 ON 05 APR 2006

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FILE 'EMBASE' ENTERED AT 12:37:38 ON 05 APR 2006

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=> s 86408-72-2/rn or ecabet or ecabet sodium or 33159-27-2/rn

'RN' IS NOT A VALID FIELD CODE

'RN' IS NOT A VALID FIELD CODE

'RN' IS NOT A VALID FIELD CODE

L1 340 86408-72-2/RN OR ECABET OR ECABET SODIUM OR 33159-27-2/RN

=> s l1 and (rectum or rectal or anus or rectus)

L2 12 L1 AND (RECTUM OR RECTAL OR ANUS OR RECTUS)

=> dup rem l2

PROCESSING COMPLETED FOR L2

L3 8 DUP REM L2 (4 DUPLICATES REMOVED)

=> focus

PROCESSING COMPLETED FOR L3

L4 8 FOCUS L3 1-

=> d ibib abs hitstr 1-8

L4 ANSWER 1 OF 8 CAPLUS COPYRIGHT 2006 ACS on STN

ACCESSION NUMBER: 2003:257795 CAPLUS

DOCUMENT NUMBER: 138:260496

TITLE: Suppositories and topical compositions containing
ecabet sodium

INVENTOR(S): Samejima, Teruyuki

PATENT ASSIGNEE(S): Amafuji Pharmaceutical Co., Ltd., Japan

SOURCE: Jpn. Kokai Tokkyo Koho, 4 pp.

CODEN: JKXXAF

DOCUMENT TYPE: Patent

LANGUAGE: Japanese

FAMILY ACC. NUM. COUNT: 1

PATENT INFORMATION:

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
JP 2003095935	A2	20030403	JP 2001-288315	20010921
PRIORITY APPLN. INFO.:			JP 2001-288315	20010921

AB The title compns. for administration to vagina, **anus**, and **rectum** comprise 1-80 % **ecabet sodium** and ≥ 1 drugs selected from the group consisting of adrenocortical hormones, local anesthetics, anti-inflammatory analgesics, antipruritics, wound-healing agents, vitamins, sulfa drugs, bactericides, vasoconstrictors, antihistamines, peripheral vasodilators, antidiarrheal agents, and antiflatulents. The compns. are especially effective for the treatment of hemorrhoid and vaginitis. The compns. can be in the forms of suppositories, ointments, aerosols, solns., suspensions, patches, poultices, liniments, or lotions. For example, suppositories were formulated containing **ecabet sodium** 350, lidocaine 60, tocopherol acetate 60, and hard fat 1280 mg/each.

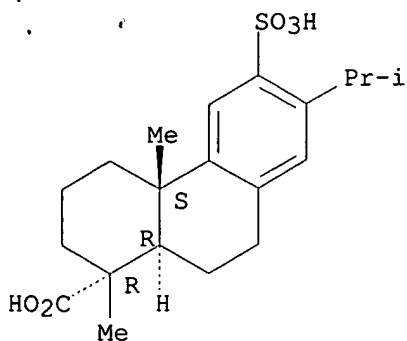
IT **86408-72-2, Ecabet sodium**

RL: THU (Therapeutic use); BIOL (Biological study); USES (Uses)
(suppositories and topicals containing **ecabet sodium**
and addnl. active ingredients for treatment of hemorrhoid and
infections)

RN 86408-72-2 CAPLUS

CN 1-Phenanthrenecarboxylic acid, 1,2,3,4,4a,9,10,10a-octahydro-1,4a-dimethyl-
7-(1-methylethyl)-6-sulfo-, monosodium salt, (1R,4aS,10aR)- (9CI) (CA
INDEX NAME)

Absolute stereochemistry.



L4 ANSWER 2 OF 8 CAPLUS COPYRIGHT 2006 ACS on STN

ACCESSION NUMBER: 2001:294454 CAPLUS

DOCUMENT NUMBER: 135:205297

TITLE: Effect of **ecabet sodium** enema on mildly to moderately active ulcerative proctosigmoiditis: An open-label study

AUTHOR(S): Kono, Toru; Nomura, Masafumi; Kasai, Shinichi; Kohgo, Yutaka

CORPORATE SOURCE: Second Department of Surgery and Third Department of Medicine, Asahikawa Medical College, Asahikawa, Japan

SOURCE: American Journal of Gastroenterology (2001), 96(3), 793-797

CODEN: AJGAAR; ISSN: 0002-9270

PUBLISHER: Elsevier Science Inc.

DOCUMENT TYPE: Journal

LANGUAGE: English

AB OBJECTIVES: **Ecabet sodium** (ES), a nonabsorbable antigastric ulcer agent, has been shown to adhere to the region of an ulcer. It topically enhances gastric mucosal defensive factors such as the endogenous prostaglandins, capsaicin-sensitive sensory nerves, nitric oxide, and mucin. All of these mucosal defensive factors play an important role in maintaining the mucosal integrity of the colon and **rectum**. Therefore, we investigated the effect of ES in patients with mildly to moderately active ulcerative proctosigmoiditis. METHODS: In an open-label study, seven patients with mildly to moderately active ulcerative colitis (UC) who had an inflamed mucosa in the **rectum** and/or sigmoid and were resistant to 4-wk topical and systemic standard treatment were treated with an ES enema b.i.d. for 14 days. The enema consisted of ES (1 g) and tepid water (20 or 50 mL). These patients were assessed by the Clin. Activity Index, colonoscopically, and histol. before and after the ES therapy. The ES therapy was started after obtaining informed consent from the patients. RESULTS: Six of the seven patients responded to therapy and achieved clin., endoscopic, and histol. remissions. One patient was withdrawn because of increased stool frequency. All six patients who completed the study showed a significant change in the mean Clin. Activity Index score from 5.3 ± 1.4 (mean \pm SD) to 0.5 ± 0.8 ($p < 0.05$), in the colonoscopic score from 3.0 ± 0.9 to 0.8 ± 0.4 ($p < 0.05$), and in the histol. score from 2.7 ± 0.5 to 0.5 ± 0.6 ($p < 0.05$), and achieved remission at the end of the study. There were no side effects attributable to the ES therapy. Five of the six patients are still in clin. remission after a median follow-up period of 5 mo. CONCLUSIONS: The ES enemas proved to be a safe and potentially useful adjuvant therapy currently available for treating patients with mildly to moderately active ulcerative proctosigmoiditis. A controlled study is necessary to confirm our results.

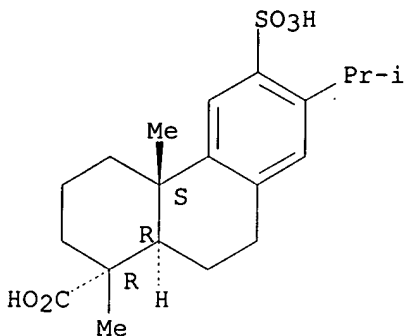
IT 86408-72-2, **Ecabet sodium**

RL: BAC (Biological activity or effector, except adverse); BSU (Biological study, unclassified); THU (Therapeutic use); BIOL (Biological study); USES (Uses)

(effect of **ecabet sodium** enema on mildly to

moderately active ulcerative proctosigmoiditis in humans)
RN 86408-72-2 CAPLUS
CN 1-Phenanthrenecarboxylic acid, 1,2,3,4,4a,9,10,10a-octahydro-1,4a-dimethyl-
7-(1-methylethyl)-6-sulfo-, monosodium salt, (1R,4aS,10aR)- (9CI) (CA
INDEX NAME)

Absolute stereochemistry.



REFERENCE COUNT: 39 THERE ARE 39 CITED REFERENCES AVAILABLE FOR THIS
RECORD. ALL CITATIONS AVAILABLE IN THE RE FORMAT

L4 ANSWER 3 OF 8 MEDLINE on STN
ACCESSION NUMBER: 1998350266 MEDLINE
DOCUMENT NUMBER: PubMed ID: 9683817
TITLE: Protective effects of an antiulcer agent, **ecabet sodium** on colorectal carcinogenesis in rodents.
AUTHOR: Yarimizu T; Mitamura T; Suzuki S; Sakamoto S
CORPORATE SOURCE: Third Internal Medicine, Oita Medical University, Oita
879-55, Japan.
SOURCE: Oncology reports, (1998 Sep-Oct) Vol. 5, No. 5, pp. 1103-7.
Journal code: 9422756. ISSN: 1021-335X.
PUB. COUNTRY: Greece
DOCUMENT TYPE: Journal; Article; (JOURNAL ARTICLE)
LANGUAGE: English
FILE SEGMENT: Priority Journals
ENTRY MONTH: 199809
ENTRY DATE: Entered STN: 19981006
Last Updated on STN: 19981006
Entered Medline: 19980921

AB A new antiulcer agent, **ecabet sodium** is one of dehydroabietic acid derivatives prepared from pine resin. The effects of **ecabet sodium** on colorectal carcinogenesis were investigated in azoxymethane-pretreated mice with chronic ulcerative colitis induced by 3 repeated administration of 3% dextran sulfate sodium and in 1, 2-dimethylhydrazine-treated rats. Although daily treatment with **ecabet sodium** did not affect the colorectal DNA-synthesizing enzyme activities and bromodeoxyuridine-immunoreactive S-phase cells, high-grade dysplasia in **ecabet sodium**-treated mice was less frequent than in untreated mice. In rats, **ecabet sodium** administration reduced the elevated activity of thymidylate synthetase in colorectal tumors.

L4 ANSWER 4 OF 8 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on STN
ACCESSION NUMBER: 2006:210147 BIOSIS
DOCUMENT NUMBER: PREV200600211876
TITLE: Efficacy of **ecabet sodium** enema on steroid-resistant or steroid-dependent ulcerative colitis.
AUTHOR(S): Itou, Hiroaki; Iizuka, Masahiro; Horie, Yasuo; Konno, Shiko; Shindo, Kenichi; Sato, Akiko; Watanabe, Sumio
SOURCE: Gastroenterology, (APR 2005) Vol. 128, No. 4, Suppl. 2, pp. A578.

Meeting Info.: Annual Meeting of the American-
Gastroenterological-Association/Digestive-Disease-Week.
Chicago, IL, USA. May 14 -19, 2005. Amer Gastroenterol
Assoc.

CODEN: GASTAB. ISSN: 0016-5085.

DOCUMENT TYPE: Conference; (Meeting)
Conference; Abstract; (Meeting Abstract)
LANGUAGE: English
ENTRY DATE: Entered STN: 29 Mar 2006
Last Updated on STN: 29 Mar 2006

AB Efficacy of **ecabet sodium** enema on steroid-resistant
or steroid-dependent ulcerative colitis Hiroaki Itou, Masahiro Iizuka,
Tomoyuki Shirasaka, Yasuo Horie, Shiho Konno, Kenichi Shindo, Akiko Sato,
Sumio Watanabe [Background] **Ecabet sodium** (ES), a
12-sulfodehydroabiatic acid monosodium salt that is derived from an
ingredient in pine tree, is shown to topically enhance several gastric
mucosal defensive factors and used in the treatment of gastritis and
gastric ulcer in Japan. However, a recent study also showed therapeutic
effects of ES enema on patients with ulcerative colitis (UC). Thus, we
attempted to investigate the efficacy of ES enema on steroid-resistant or
steroid-dependent UC patients. [Methods] Treatment with ES enema was
performed under informed consent in 6 patients with intractable UC
patients Sex: male 3, female 3, Age: 23-45 yrs (mean 36.3 yrs), who had an
inflamed mucosa in the **rectum** and sigmoid colon except one
patient having ileal pouchitis after total proctocolectomy. Five patients
were steroid-resistant and one was steroid-dependent. ES enema was
prepared with 1 gram ES and 20-50ml of tepid water, and two enemas per day
were instilled into the **rectum**. Disease activity was assessed
before and after the treatment by Ulcerative Colitis-Disease Activity
Index (UC-DAI). [Results] One patient was withdrawn because of an increase
of bowel movements. Three of five patients significantly responded to the
treatment and achieved clinical remission in 2-8 weeks (mean 4 weeks).
Two patients slightly responded to the treatment, but they did not achieve
clinical remission, Mean points of UC-DAI was significantly decreased
after ES enema treatment (4.8 +/- 2.3) compared to that before the
treatment (10.8 +/- 1.0) (p= 0.0423). [Conclusion] Our results suggest
that ES enema also has therapeutic effects on some steroid-resistant or
steroid-dependent UC patients.

L4 ANSWER 5 OF 8 EMBASE COPYRIGHT (c) 2006 Elsevier B.V. All rights
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ACCESSION NUMBER: 2005074491 EMBASE
TITLE: A case of radiation colitis improved with **ecabet**
sodium enema.
AUTHOR: Kuriyama M.; Kato J.; Imagawa A.; Hori S.; Kawamoto H.;
Okada H.; Shiratori Y.
SOURCE: Gastroenterological Endoscopy, (2005) Vol. 47, No. 1, pp.
32-36. .
Refs: 18
ISSN: 0387-1207 CODEN: NNAGAG
COUNTRY: Japan
DOCUMENT TYPE: Journal; Article
FILE SEGMENT: 014 Radiology
037 Drug Literature Index
048 Gastroenterology
LANGUAGE: Japanese
SUMMARY LANGUAGE: English; Japanese
ENTRY DATE: Entered STN: 3 Mar 2005
Last Updated on STN: 3 Mar 2005

AB A 73-year-old man received radiation therapy (external radiation with 70
Gy) for carcinoma of the prostate. Bleeding at the **rectum**
occurred approximately eight months after irradiation. Severe bleeding
and anemia could not be controlled by hyperbaric oxygen therapy, argon
plasma coagulation and sucralfate enemas. Therefore, we treated this
patient with **ecabet sodium** enema, which is reported to
be effective on ulcerative colitis. Bleeding and anemia gradually
improved with this treatment. It is suggested that **ecabet**
sodium enema can be an available treatment for radiation colitis.

L4 ANSWER 6 OF 8 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on STN
ACCESSION NUMBER: 2001:456184 BIOSIS
DOCUMENT NUMBER: PREV200100456184
TITLE: A case of radiation colitis improved by enema therapy with
ecabet sodium.
AUTHOR(S): Matsumoto, M. [Reprint author]; Maruta, M. [Reprint
author]; Maeda, K. [Reprint author]; Utsumi, T. [Reprint
author]; Sato, Y. [Reprint author]; Takizawa, K. [Reprint
author]; Masumori, K. [Reprint author]; Matsuoka, H.
[Reprint author]
CORPORATE SOURCE: Department of Surgery, Fujita Health University School of
Medicine, Toyoake, Aichi, Japan
SOURCE: Journal of the Japan Society of Coloproctology, (July,
2001) Vol. 54, No. 7, pp. 489-492. print.
CODEN: NDKGAU. ISSN: 0047-1801.
DOCUMENT TYPE: Article
LANGUAGE: Japanese
ENTRY DATE: Entered STN: 26 Sep 2001
Last Updated on STN: 22 Feb 2002

AB Radiation therapy is one choice for malignant disease of the lower
abdomen. However, radiation sometimes induces radiation colitis as a
severe side effect. Radiation colitis sometimes causes severe bleeding,
and it is often difficult to treat. A 66-year-old man received radiation
therapy (external radiation with 65.2 Gy) for carcinoma of the bladder.
Bleeding in the **rectum** occurred approximately 15 months after
irradiation. Severe bleeding and anemia could not be controlled by
Salazosulfapyridine(R) and steroid enemas, and frequent blood transfusion
was needed. Therefore, we gave **ecabet sodium** enemas
to this patient, twice every day, for four weeks. Bleeding and anemia
could be controlled by this treatment. It is suggested that
ecabet sodium enema can be an available treatment for
radiation colitis.

L4 ANSWER 7 OF 8 MEDLINE on STN
ACCESSION NUMBER: 2005265108 MEDLINE
DOCUMENT NUMBER: PubMed ID: 15906769
TITLE: Therapeutic effects of **ecabet sodium**,
an antiulcer drug, on dextran sodium sulfate-induced
ulcerative colitis in rats.
AUTHOR: Noto Tsunehisa; Yamada Hiroshi; Inui Takashi; Okuyama
Kayoko; Watanabe Ayako; Kimura Isami; Nagasaki Masaaki
CORPORATE SOURCE: Discovery & Pharmacology Research Laboratories, Toda,
Saitama, Japan.. t-noto@tanabe.co.jp
SOURCE: Digestive diseases and sciences, (2005 May) Vol. 50, No. 5,
pp. 922-7.
Journal code: 7902782. ISSN: 0163-2116.
PUB. COUNTRY: United States
DOCUMENT TYPE: Journal; Article; (JOURNAL ARTICLE)
LANGUAGE: English
FILE SEGMENT: Abridged Index Medicus Journals; Priority Journals
ENTRY MONTH: 200506
ENTRY DATE: Entered STN: 20050524
Last Updated on STN: 20050610
Entered Medline: 20050609

AB **Ecabet**, an antiulcer drug, is reported to be effective in
patients with ulcerative colitis. We investigated the effect of
ecabet enema on ulcerative colitis in rats and some mechanisms
underlying this effect. In vivo **ecabet** enema showed a
therapeutic effect in the rat ulcerative colitis model induced by dextran
sodium sulfate in the drinking water. The amount of **ecabet**
bound to damaged mucosa was higher than that bound to normal mucosa 30 min
after intrarectal administration. In vitro **ecabet** accelerated
the restitution of epithelial cells, which was not affected by a TGF-beta
antibody. **Ecabet** inhibited the leukotriene B4 production and
5-lipoxygenase activity in human neutrophils. In conclusion,
ecabet enema showed a therapeutic effect in rats with ulcerative
colitis. This effect may be attributable to the high binding affinity for
damaged mucosa, the acceleration of restitution, and the inhibition of
leukotriene B4 production.

L4 ANSWER 8 OF 8 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on STN
 ACCESSION NUMBER: 2002:499956 BIOSIS
 DOCUMENT NUMBER: PREV200200499956
 TITLE: A successful treatment for cap polyposis by oral steroid
 administration and **ecabet sodium** enema,
 report of a case.
 AUTHOR(S): Ogino, Hidero [Reprint author]; et al
 CORPORATE SOURCE: Department of Internal Medicine, Toyama Prefectural Central
 Hospital, Toyama, Japan
 SOURCE: Stomach and Intestine (Tokyo), (April, 2002) Vol. 37, No.
 5, pp. 735-740. print.
 ISSN: 0536-2180.
 DOCUMENT TYPE: Article
 LANGUAGE: Japanese
 ENTRY DATE: Entered STN: 25 Sep 2002
 Last Updated on STN: 25 Sep 2002

AB A 41-year-old woman was admitted to our hospital with the complaint of
 lower abdominal pain and bloody mucous stool. She had a prior diagnosis
 of ulcerative colitis, which had been unsuccessfully treated with
 sala-zosulphapyridine two years before admission to our hospital.
 Clinical examination showed severe hypoproteinemia and mild anemia.
 Barium enema and colonoscopy revealed multiple variously formed polyps
 with redness and erosion from the **rectum** to the transverse
 colon. Biopsy specimens showed superficial erosion with elongated
 hyperplastic glands. These findings suggested cap polyposis. The patient
 responded to the combination therapy of oral steroid administration and
ecabet sodium enema. She achieved clinical and
 endoscopic remission after 4 weeks.

=> file medline

COST IN U.S. DOLLARS	SINCE FILE	TOTAL
	ENTRY	SESSION
FULL ESTIMATED COST	49.48	50.13
DISCOUNT AMOUNTS (FOR QUALIFYING ACCOUNTS)	SINCE FILE	TOTAL
	ENTRY	SESSION
CA SUBSCRIBER PRICE	-1.50	-1.50

FILE 'MEDLINE' ENTERED AT 12:41:05 ON 05 APR 2006

FILE LAST UPDATED: 4 APR 2006 (20060404/UP). FILE COVERS 1950 TO DATE.

On December 11, 2005, the 2006 MeSH terms were loaded.

The MEDLINE reload for 2006 is now (26 Feb.) available. For details
 on the 2006 reload, enter HELP RLOAD at an arrow prompt (=>).
 See also:

<http://www.nlm.nih.gov/mesh/>
http://www.nlm.nih.gov/pubs/techbull/nd04/nd04_mesh.html
http://www.nlm.nih.gov/pubs/techbull/nd05/nd05_med_data_changes.html
http://www.nlm.nih.gov/pubs/techbull/nd05/nd05_2006_MeSH.html

OLDMEDLINE is covered back to 1950.

MEDLINE thesauri in the /CN, /CT, and /MN fields incorporate the
 MeSH 2006 vocabulary.

This file contains CAS Registry Numbers for easy and accurate
 substance identification.

=> file caplus medline biosis embase

COST IN U.S. DOLLARS	SINCE FILE	TOTAL
	ENTRY	SESSION
FULL ESTIMATED COST	0.39	50.52
DISCOUNT AMOUNTS (FOR QUALIFYING ACCOUNTS)	SINCE FILE	TOTAL

CA SUBSCRIBER PRICE

ENTRY SESSION
0.00 -1.50

FILE 'CAPLUS' ENTERED AT 12:41:13 ON 05 APR 2006
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=> s artificial anus periphery or artificial anus
L5 296 ARTIFICIAL ANUS PERIPHERY OR ARTIFICIAL ANUS

=> s 15 and (ibd or inflammatory bowel disease or crohn or colitis or puchitis or behcet or ulcer)
L6 14 L5 AND (IBD OR INFLAMMATORY BOWEL DISEASE OR CROHN OR COLITIS
 OR PUCHITIS OR BEHCET OR ULCER)

=> dup rem 16
PROCESSING COMPLETED FOR L6
L7 13 DUP REM L6 (1 DUPLICATE REMOVED)

=> focus
PROCESSING COMPLETED FOR L7
L8 13 FOCUS L7 1-

=> d ibib abs 1-13 hitstr

L8 ANSWER 1 OF 13 CAPLUS COPYRIGHT 2006 ACS on STN
ACCESSION NUMBER: 2005:299438 CAPLUS
DOCUMENT NUMBER: 142:360848
TITLE: Pharmaceuticals for treatment of **inflammatory**
 bowel disease by intrarectal
 administration
INVENTOR(S): Shirae, Hideyuki
PATENT ASSIGNEE(S): Ajinomoto Co., Inc., Japan
SOURCE: Jpn. Kokai Tokkyo Koho, 9 pp.
 CODEN: JKXXAF
DOCUMENT TYPE: Patent
LANGUAGE: Japanese
FAMILY ACC. NUM. COUNT: 1
PATENT INFORMATION:

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
JP 2005089306	A2	20050407	JP 2003-320628	20030912
PRIORITY APPLN. INFO.:			JP 2003-320628	20030912

AB Title pharmaceuticals, e.g. suppositories, foaming agents, or enemas, useful for treatment of skin inflammation around **artificial anus**, burrow in patients with **Crohn's** disease, or anal fistula, contain activated C as active ingredient, and optionally steroids, immunosuppressants, etc. Thus, activated C-containing suppositories and enemas were formulated.

L8 ANSWER 2 OF 13 EMBASE COPYRIGHT (c) 2006 Elsevier B.V. All rights reserved on STN
ACCESSION NUMBER: 74048430 EMBASE
DOCUMENT NUMBER: 1974048430
TITLE: Two cases of ulceration in babies extending from the rectum to the anus (Japanese).
AUTHOR: Takano M.; Sumikoshi Y.
CORPORATE SOURCE: Proctol. Cent., Soc. Insur. Cent. Hosp., Tokyo, Japan
SOURCE: Stomach and Intestine, (1973) Vol. 8, No. 6, pp. 791-796. .

CODEN: ITCHAG
DOCUMENT TYPE: Journal
FILE SEGMENT: 048 Gastroenterology
007 Pediatrics and Pediatric Surgery
009 Surgery
LANGUAGE: Japanese

AB Extensive **ulcers**, arising shortly after birth and extending from the lower part of the rectum out through the anus over to the perineal region, were encountered in 2 babies, a 6 mth old male and a 2 mth old female. The **ulcers**, shallow and free from coat, did not form a tumor mass. Pathologically, these **ulcers** were nonspecific inflammatory **ulcers** different from those seen in ulcerative **colitis** or **Crohn's** disease in the adult. The **ulcers** produced local pain, tenesmus and diarrhea to such a degree as to jeopardize life. These **ulcers** did not respond well to medication of corticosteroids and antibiotics, and only after an **artificial anus** was made in the colon above the ulcerations, and stools were prevented from passing the diseased segment, did the severe symptoms subside, resulting in survival of the babies. Both cases were complicated with aphthae in the mouth together with inflammatory pharyngeal polyposis. A tendency to ulceration along the entire length of the digestive tract was suggested by these findings. It seems that the rectoanal **ulcers** seen in these babies comprise a new pathological entity as yet unreported in the literature. No hereditary or embryologic abnormality was recognized.

L8 ANSWER 3 OF 13 CAPLUS COPYRIGHT 2006 ACS on STN

ACCESSION NUMBER: 1999:147422 CAPLUS
DOCUMENT NUMBER: 130:200956
TITLE: Activated carbon fibers as deodorants for medical goods
INVENTOR(S): Yoshimura, Masaya; Takimoto, Nobuyuki; Tsuruya, Ryoichi
PATENT ASSIGNEE(S): Unitika Ltd., Japan
SOURCE: Jpn. Kokai Tokkyo Koho, 3 pp.
CODEN: JKXXAF
DOCUMENT TYPE: Patent
LANGUAGE: Japanese
FAMILY ACC. NUM. COUNT: 1
PATENT INFORMATION:

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
JP 11056996	A2	19990302	JP 1997-225981	19970822
PRIORITY APPLN. INFO.:			JP 1997-225981	19970822

AB Medical dressings for bed sores, **ulcers**, and infection wounds and covers for **artificial anus** and bladder, comprise activated carbon fibers for deodorization.

L8 ANSWER 4 OF 13 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on STN

ACCESSION NUMBER: 1982:309392 BIOSIS
DOCUMENT NUMBER: PREV198274081872; BA74:81872
TITLE: A CASE OF **CROHNS** DISEASE COMPLICATED WITH FREE PERFORATION.
AUTHOR(S): NAKAIZUMI O [Reprint author]; YAMAZAKI S; KONISHI F
CORPORATE SOURCE: DEP SURGERY, FUKUI PREFECTURAL HOSP, FUKUI, JPN
SOURCE: Stomach and Intestine (Tokyo), (1982) Vol. 17, No. 4, pp. 441-446.
ISSN: 0536-2180.
DOCUMENT TYPE: Article
FILE SEGMENT: BA
LANGUAGE: JAPANESE

AB A 53-yr-old man with left-sided **Crohn's** disease complicated with free perforation of the sigmoid colon is presented. The patient was treated with Salazopyrin (salicylazosulfapyridine) for .apprx. 1 yr. Diarrhea, however, became more frequent and was accompanied with bulbar subconjunctival bleeding, fever and arthralgia. After the administration of prednisone (30 mg/day), all the symptoms were greatly alleviated. In the course of gradually decreasing the administration of the steroid (on

the 76th day since the beginning of steroid therapy), perforation of the colon took place. The descending colon and the sigmoid were resected and an **artificial anus** colostomy was also performed. The rectum was left as is. The resected specimen showed 8 longitudinal **ulcers** that were arranged in 3 rows. Most of them were located along the teniae coli. The central part of the longest **ulcer**, located on the free side of the teniae coli of the sigmoid, was perforated. Fissuring **ulcers** and granuloma were histologically recognized. In the remnant rectum, densely distributed small protrusions with aphthous **ulcers** on the tip of each of them, were seen. Such changes had been noticed even before the operation. Granulomas were demonstrated by exploratory resection of the mucosa.

L8 ANSWER 5 OF 13 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on STN
ACCESSION NUMBER: 1990:412729 BIOSIS
DOCUMENT NUMBER: PREV199090073530; BA90:73530
TITLE: ANIMAL EXPERIMENT ON ABDOMINAL ANUS WITH INTUSSUSCEPTED VALVE.
AUTHOR(S): OUYANG Z [Reprint author]; HUANG S; G M; LIU X; CHEN X; WEN J
CORPORATE SOURCE: DEP OPERATIVE SURG, HUNAN MED UNIV, CHINA
SOURCE: Hunan Yike Daxue Xuebao, (1990) Vol. 15, No. 2, pp. 177-180.
ISSN: 1000-5625.
DOCUMENT TYPE: Article
FILE SEGMENT: BA
LANGUAGE: CHINESE
ENTRY DATE: Entered STN: 17 Sep 1990
Last Updated on STN: 17 Sep 1990

AB Intussuscepted valves on the colon 3 .apprx. 4 cm above the colostomic stoma in an animal experiment on abdominal **artificial anus**. 15 dogs were divided into a complete valve group, an incomplete valve group and a group without valves. Normal defecation of each dog which was 1 .apprx. 3 times per day was observed. After operation, all received normal feeding for 94 .apprx. 107 days. Defecation of the complete valve group was 2 .apprx. 3 times per day, the incomplete valve group 4 .apprx. 6 times per day, while the defecation in the group without valves occurred incontinence. Afterward, the valves and colon within 10 cm above, the **artificial anus** all cut off and examined. The surface of the valves was smooth, there were no inflammation, **ulcer**, fibrous proliferation, degeneration or necrosis, the smooth muscular layer within the valve thickened obviously. However, the results of the examination on the colostomic opening were complete opposite. All the results showed that the intussuscepted intestinal valves had obvious "sphincteric" function and no obstruction occurred on the colon above the valves. This means that the valves can control the incontinence of stool effectively.

L8 ANSWER 6 OF 13 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on STN
ACCESSION NUMBER: 1997:246919 BIOSIS
DOCUMENT NUMBER: PREV199799546122
TITLE: Recurrent unclassified **ulcer** of the colon and terminal ileum, report of a case.
AUTHOR(S): Adachi, Kyoichi [Reprint author]; Suetsugu, Hiroshi; Hidaka, Katsuko; Fukumoto, Shiro; Nagaoka, Saburo
CORPORATE SOURCE: Dep. Intern. Med. II, Shimane Med. Univ., 89-1 Enya-cho, Izumo 693, Japan
SOURCE: Stomach and Intestine (Tokyo), (1997) Vol. 32, No. 2, pp. 203-211.
ISSN: 0536-2180.
DOCUMENT TYPE: Article
LANGUAGE: Japanese
ENTRY DATE: Entered STN: 13 Jun 1997
Last Updated on STN: 13 Jun 1997

AB The patient was a 44-year-old woman who visited our hospital in June, 1991 because of low grade fever, diarrhea, and left lower abdominal pain. Ba-enema and colonoscopy revealed liner ulceration of the rectosigmoid area. Lower anterior resection was carried out because of enlargement of the ulceration and severe abdominal pain. Histo-pathological examination

showed non-specific findings and the lesion was diagnosed as unclassified **ulcer**. Postoperatively, pain disappeared, but one month and a half after the operation, **ulcer** recurred in the anastomotic area and the severe pain reappeared. The second operation (resection of the rectum and the sigmoid colon) was performed because of the severe pain. The third operation (resection of sigmoid and descending colon) and the fourth operation (resection of the transverse and ascending colon, and cecum) was done because of perforation by the recurring ulceration at the oral side of the **artificial anus**. Histologically, all the resected specimens were diagnosed as unclassified **ulcers**. Two months after the fourth operation, endoscopy revealed recurrence of the ulceration in the terminal ileum. Neither steroid nor alimental diet therapy, nor intravenous hyperalimentation were effective for **ulcer** healing and relief of abdominal pain.

L8 ANSWER 7 OF 13 MEDLINE on STN
ACCESSION NUMBER: 92095224 MEDLINE
DOCUMENT NUMBER: PubMed ID: 1661562
TITLE: A case of cytomegalovirus infection that caused gastrointestinal perforation after surgery for cancer of the bladder.
AUTHOR: Miyauchi T; Maruoka M; Nagayama T; Matsuzaki O; Wakatsuki S
CORPORATE SOURCE: Department of Urology, Chiba Cancer Center Hospital.
SOURCE: Hinyokika kiyo. Acta urologica Japonica, (1991 Oct) Vol. 37, No. 10, pp. 1319-22.
Journal code: 0421145. ISSN: 0018-1994.
PUB. COUNTRY: Japan
DOCUMENT TYPE: (CASE REPORTS)
Journal; Article; (JOURNAL ARTICLE)
LANGUAGE: Japanese
FILE SEGMENT: Priority Journals
ENTRY MONTH: 199201
ENTRY DATE: Entered STN: 19920216
Last Updated on STN: 19920216
Entered Medline: 19920127

AB A 78-year-old man visited our department for macroscopic hematuria in June, 1989. On the basis of the diagnosis of tumor of the bladder and right afunctional kidney, total right nephro-uretero-cystectomy and skin grafting of the left ureter were performed on August 2. The patient continued to have fever of unknown origin postoperatively. Repeat laparotomy, which was performed for rectal fistula on August 25, revealed that the abdominal wall, colon, small intestine and mesenterium adhered to one another, producing a mass and that two sites in the rectum were perforated. A part of the small intestine was excised, the perforated sites were sutured, and an **artificial anus** was created at the transverse colon. Since the patient had intermittent fever and continued to complain of abdominal pain after creation of the **artificial anus**, nosotropic therapy was continued. However, the patient died from cardiac insufficiency on October 10. Erosion and **ulcer** were histologically observed over a wide range in the excised small intestine. In addition there was a defect in one area of the small intestine, penetrating the tunica muscularis propria, in which many cytomegalovirus (CMV) inclusion bodies were observed. CMV inclusion bodies were also detected in the bladder with re-examination of specimens from the excised bladder. From these findings, it appears that endogenous CMV may have been reactivated in the present case.

L8 ANSWER 8 OF 13 MEDLINE on STN
ACCESSION NUMBER: 2001086311 MEDLINE
DOCUMENT NUMBER: PubMed ID: 11138541
TITLE: Squamous cell carcinoma arising in chronic perianal pyoderma a case report and review of Japanese literature.
AUTHOR: Ishizawa T; Koseki S; Mitsunashi Y; Kondo S
CORPORATE SOURCE: Department of Dermatology, Yamagata University School of Medicine, 2-2-2 Iida-Nishi, Yamagata, Yamagata 990-9585, Japan.
SOURCE: The Journal of dermatology, (2000 Nov) Vol. 27, No. 11, pp. 734-9. Ref: 11
Journal code: 7600545. ISSN: 0385-2407.

PUB. COUNTRY: Japan
DOCUMENT TYPE: (CASE REPORTS)
Journal; Article; (JOURNAL ARTICLE)
General Review; (REVIEW)
LANGUAGE: English
FILE SEGMENT: Priority Journals
ENTRY MONTH: 200101
ENTRY DATE: Entered STN: 20010322
Last Updated on STN: 20010322
Entered Medline: 20010118

AB We report a rare case of squamous cell carcinoma developing from fistules of chronic perianal pyoderma in a 49-year-old Japanese man. He first noticed an abscess and nodule on his buttocks and perianal area 21 year previously (at the age of 28); the fistules formed later. These fistules were surgically removed, and an **artificial anus** was constructed 14 years ago (at the age of 35) in our hospital, when a histopathological examination revealed no malignant changes. However, he was recently admitted to our hospital with arterial bleeding from the **ulcer** of the buttock. On admission, the histological diagnosis of the **ulcer** was well differentiated squamous cell carcinoma. Wide local excision of the **ulcer** and scar tissue, including the sacrum, was performed. The defect was covered with a left latissimus dorsi flap and skin graft. He received radiation therapy after the operation. However, he died of cachexia and pneumonia. This case indicated that the CPP would better have been treated with wide excision before the development of SCC. Therefore, we recommend careful follow-up of patients affected by CPP and repeated biopsies of the lesion, particularly when the condition is severe, longstanding, and extensive. We discussed the term "CPP" and reviewed 22 cases of SCC arising in CPP reported in the Japanese literature.

L8 ANSWER 9 OF 13 MEDLINE on STN
ACCESSION NUMBER: 77004795 MEDLINE
DOCUMENT NUMBER: PubMed ID: 964896
TITLE: [Artificial anus. Advantages and disadvantages of ileo- and colostomy].
Anus praeter. Vor- und Nachteile von Ileo- und Kolostomie.
AUTHOR: Kock N G
SOURCE: Fortschritte der Medizin, (1976 Mar 11) Vol. 94, No. 8, pp. 401-4.
Journal code: 2984763R. ISSN: 0015-8178.
PUB. COUNTRY: GERMANY, WEST: Germany, Federal Republic of
DOCUMENT TYPE: Journal; Article; (JOURNAL ARTICLE)
LANGUAGE: German
FILE SEGMENT: Priority Journals
ENTRY MONTH: 197611
ENTRY DATE: Entered STN: 19900313
Last Updated on STN: 19900313
Entered Medline: 19761121

AB The majority of patients with ileostomy adapt to their new situation and are able to live a nearly normal professional and social life. This does not mean that there is not a need for improvement in the ileostomy construction. It merely proves the great adaptive mechanism in man. In spite of the improvement in surgical techniques in the construction of the ileostomy and the development of modern ileostomy appliances, a proportion of the patients still experiences serious problems. In order to improve the situation for patients with ileostomy a new type of ileostomy has been developed. From the terminal ileum an intraabdominal, intestinal reservoir is constructed and the outlet from the reservoir is provided with a "nipple valve" preventing leakage of gas and faeces through the outlet. The continent ileostomy has now been under clinical trial for more than seven years. The success-rate has increased along with improvements in technique and introduction of methodological modifications. More than 90% of 164 patients provided with this type of ileostomy had at follow-up satisfactory functional results of their ileostomy. That means that they had no need for carrying external ileostomy appliances. A method for constructing a continent colostomy has been tested in dogs. The sigmoid colon was divided and the distal end closed. At the proximal end a "nipple valve" was constructed by

intussuscepting a part of the intestine into its lumen. All dogs were continent from the time of operation until they were sacrificed one to eight weeks later. The method is now under elaboration for clinical trial.

L8 ANSWER 10 OF 13 MEDLINE on STN
ACCESSION NUMBER: 72001293 MEDLINE
DOCUMENT NUMBER: PubMed ID: 4937366
TITLE: [Preterminal dilatation plasty in the **artificial**
anus made from ileum].
Praterminale Erweiterungsplastik beim Ileum-Kunstafter.
AUTHOR: Rehner M; Soehendra N; Schreiber H W
SOURCE: Der Chirurg; Zeitschrift für alle Gebiete der operativen
Medizin, (1971 Sep) Vol. 42, No. 9, pp. 420-1.
Journal code: 16140410R. ISSN: 0009-4722.
PUB. COUNTRY: GERMANY, WEST: Germany, Federal Republic of
DOCUMENT TYPE: Journal; Article; (JOURNAL ARTICLE)
LANGUAGE: German
FILE SEGMENT: Priority Journals
ENTRY MONTH: 197111
ENTRY DATE: Entered STN: 19900310
Last Updated on STN: 19900310
Entered Medline: 19711130

L8 ANSWER 11 OF 13 BIOSIS COPYRIGHT (c) 2006 The Thomson Corporation on
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ACCESSION NUMBER: 1990:37106 BIOSIS
DOCUMENT NUMBER: PREV199038016336; BR38:16336
TITLE: DIET THERAPY STOMACH INTESTINE LIVER GALLBLADDER PANCREAS
DIET BOOK FOR PATIENTS AND DIETICIANS.
AUTHOR(S): VETTER K; HIRTE C
SOURCE: (1988) pp. 192P. VETTER, K. AND C. HIRTE. DIAETBEHANDLUNG:
MAGEN, DARM, LEBER, GALLE, BAUCHSPEICHELDRUESE: DIAETBUCH
FUER PATIENTEN UND DIAETASSISTENTEN (DIET THERAPY: STOMACH,
INTESTINE, LIVER, GALLBLADDER, PANCREAS: DIET BOOK FOR
PATIENTS AND DIETICIANS). 192P. VEB VERLAG VOLK UND
GESUNDHEIT: BERLIN, EAST GERMANY. ILLUS. PAPER.
ISBN: 3-333-00245-0.
DOCUMENT TYPE: Book
FILE SEGMENT: BR
LANGUAGE: GERMAN
ENTRY DATE: Entered STN: 28 Dec 1989
Last Updated on STN: 28 Dec 1989

AB This manual seeks to afford an understanding of available dietetic measures and to facilitate the implementation of diets. The work begins with a short discussion of the structure and function of the organ systems involved. The chapter immediately following covers the basic principles of diets in diseases of these organs. This section provides information on the origin, symptoms and dietetic treatment for a variety of diseases, including acute and chronic gastritis, ulcerous **colitis** and hepatitis. A short discussion of treatment with the basic diet follows. This brief assessment delineates the 3 forms of this diet (strictest, strict and expanded forms) and discusses basic ingredients and preparation techniques. A chapter on special diets covers conditions such as the dumping syndrome, **artificial anus** and the situation following pancreatectomy. The remainder of the work presents daily diet plans for the basic and the special diets. Tables supplement the text.

L8 ANSWER 12 OF 13 EMBASE COPYRIGHT (c) 2006 Elsevier B.V. All rights reserved on STN
ACCESSION NUMBER: 2002336206 EMBASE
TITLE: Artificial anal sphincter: Complications and functional results of a large personal series.
AUTHOR: Devesa J.M.; Rey A.; Hervas P.L.; Halawa K.S.; Larranaga I.; Svidler L.; Abaira V.; Muriel A.
CORPORATE SOURCE: Dr. J.M. Devesa, Division of Colon Surgery, University Hospital Ramon y Cajal, Madrid, Spain
SOURCE: Diseases of the Colon and Rectum, (2002) Vol. 45, No. 9, pp. 1154-1163. .

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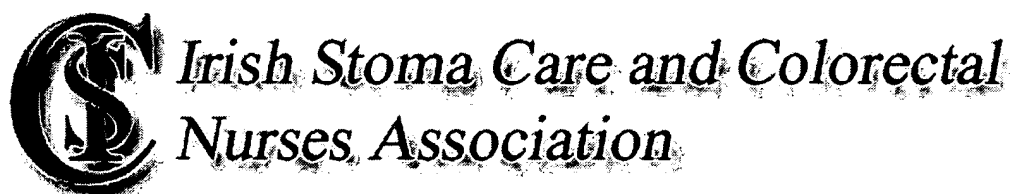
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[q=cache:w4nBv41P2u0J:www.ncnm.ie/isccna/colorectal.htm+inflammatory+bowel+disease+artificial+anus&hl=en&gl=us&ct=clnk&cd=1](http://www.google.com/search?q=cache:w4nBv41P2u0J:www.ncnm.ie/isccna/colorectal.htm+inflammatory+bowel+disease+artificial+anus&hl=en&gl=us&ct=clnk&cd=1)

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Inflammatory Bowel Disease

Inflammatory Bowel Disease (IBD) is a condition where the **bowel** becomes red and inflamed. There are two main types of IBD: **Crohn's disease** and **ulcerative colitis**. Although they have many similarities they are distinctly different diseases and both can have flare-ups (relapses) and periods of well-being (remissions). Both usually affect people aged 20-40 years but can sometimes occur in children and the elderly.

Ulcerative Colitis is inflammation of the outer lining of the colon (large **bowel**) only, hence the term colitis.

Crohn's **disease**, named after the gastroenterologist Burrill Bernard Crohn, can affect any part of the gut from the mouth to the **anus**, but most commonly affects the colon or ileum (small **bowel**) and can involve the full thickness of the **bowel** wall.

Symptoms

Both types of **inflammatory bowel disease** may have similar symptoms depending on the site and severity of the inflammation.

Ulcerative Colitis

During periods of remission people with ulcerative colitis feel well most of the time. However, during a flare-up the following symptoms can occur:

- Frequent passage of blood, mucus or loose stool, often associated with the need to go to the toilet urgently.
- Diarrhoea which may be severe

- Abdominal pain
- Tiredness and lack of energy

More rarely there may be:

- Weight loss
- Loss of appetite
- Fever

Crohn's Disease

This **disease** also has periods of remission and flare-ups but the pattern of the **disease** can be more varied as Chron's **disease** can affect any part of the **bowel**. During a relapse the main symptoms are:

- Diarrhoea, occasionally with bleeding
- Abdominal pain, crampy pains and bloating
- Weight loss and poor absorption of nutrients
- Abscesses or collections of pus
- Fistulae, abnormal channels between **bowel** and the skin or other organs such as the bladder

Other Symptoms

In addition to those listed above, both types of IBD can be associated with symptoms that manifest outside of the gut. These are far less common and can affect the following:

- Inflammation of the joints
- Thickened, painful red skin, especially on the shins
- Painful, gritty, watery eyes
- Jaundice and impaired digestion.

Treatments

Medical Treatment

The principles of both types of IBD are similar but there are important differences.

Drugs for Ulcerative Colitis

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- Steroids, for example prednisolone, can be used to alleviate acute attacks and can be very effective. However, these may be associated with side effects such as high blood pressure, water retention and osteoporosis. Steroids can be given orally, by injections or as enemas. Once a person has overcome an acute attack, steroids are gradually withdrawn.
- 5-ASA drugs such as mesalazine, are also used to treat the inflammation and can be taken in tablet, suppository or enema form. These drugs are often used during both flare-ups and as a regular medication to prevent relapses.
- Azathioprine

Drugs for Chron's Disease

Steroids are used as for ulcerative colitis

5-ASA drugs can be used as for ulcerative colitis

Antibiotics, such as metronidazole, may be used for acute attacks, particularly if the **disease** involves the **anus** and rectum.

Azathioprine is being increasingly used to try to avoid the use of steroids and to prevent **disease** flare-ups. These drugs have particular side effects such as allergic reaction and a predisposition to infection and require careful supervision by your doctor.

It is very important to take the medications as prescribed, even if you are feeling well, if this is what your doctor suggests as this will help keep the diseases in remission and prevent flare-ups.

Surgical Treatment

Although some patients may never need an operation surgical treatment may be used for the following reasons:

- Failure to respond to medical treatment
- Acute deterioration of symptoms where there is a danger of rupture (perforation) of the **bowel**
- The development of cancer or pre-cancerous tissue change

Surgery for Ulcerative Colitis

This usually involves the removal of the colon and sometimes also the rectum. This necessitates the formation of an ileostomy which may be permanent or temporary. In some cases a special pouch can be formed from the remaining small **bowel** to function as an **artificial** rectum. The normal sphincter mechanism is left intact to ensure normal continence. Please see your local Stoma Care and/or colorectal nurse specialist for further information on this type of

surgery.

It should be remembered that even though surgery is only performed if absolutely necessary, removal of the colon is a cure for ulcerative colitis and people often experience a greatly improved quality of life after surgery.

Surgery for Crohn's Disease

People with Crohn's **disease** are more likely to require surgery to:

- Remove parts of the large or small **bowel** that are diseased (this may or may not result in the formation of a stoma)
- Deal with narrowing (strictures) or fistulas
- Drain abscesses.

Diet

A key component in the treatment of IBD is a healthy diet. A balanced diet from all food groups is recommended to ensure and adequate supply of carbohydrates, proteins and fats. This includes grains, dairy, fruit and vegetables, meat and alternatives. A balanced diet gives the body the nutrients needed for growth, to repair damage and fight illness.

Most people with IBD know which foods they can tolerate and in general it is spicy, fatty and raw foods more difficult to digest. Some people often feel 'full' so eating smaller, more frequent meals can improve low energy levels and supply needed nutrients. If the **disease** is severe it may be necessary to take nutritional supplements to help prevent weight loss, to restore the balance of nutrients, to allow the **bowel** to rest and to possibly relieve pain.

Further advice is available from your colorectal nurse specialist or dietician.

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Inflammatory Bowel Disease

Inflammatory bowel disease (IBD) is a term used to describe two similar, yet distinct conditions: Crohn's **disease** and ulcerative colitis. IBD is also known by other names including: Crohn's colitis, ileitis, distal colitis and pancolitis. These diseases affect the digestive system and cause the intestines to become inflamed, form sores, bleed easily, scar and lose the normal smoothness of their inner lining. Symptoms of IBD include abdominal pain, cramping, fatigue and diarrhea.

Crohn's disease can affect any part of the gastrointestinal tract, from the mouth to the **anus**. Patches of inflammation occur, with healthy tissue between diseased areas; these are called "skip lesions". The inflammation can extend through every layer of affected **bowel** tissue. Crohn's **disease** cannot be cured by drugs or surgery, although either or both can relieve the symptoms.

Ulcerative colitis affects only the colon (large **bowel**), and only a single layer of **bowel** tissue: the inner lining. The **disease** always starts in the portion of the colon called the rectum, and may extend as a continuous (not patchy) inflammation from there into the rest of the colon. Usually, ulcerative colitis can be controlled with medication. The **disease** can be completely eliminated by surgically removing the colon, but afterward, waste material (stool) may have to be stored and expelled through an external appliance.

IBD is unpredictable. Many people experience "flare-ups" (attacks) and then the **disease** seemingly goes away. The quiet periods are called "remission" and can vary in length from weeks to years. Most people will "relapse" and have multiple attacks. IBD symptoms may also vary in severity. Some people have mild symptoms and can be treated with a combination of drugs and nutritional therapy, while others experience debilitating symptoms and need to take potent drugs, visit hospital frequently, and/or have surgery.

Signs and Symptoms

Since the **disease** can affect any part of the gastrointestinal tract, people with **Crohn's disease** have very diverse symptoms. Most commonly, the **disease**

involves the ileum or the colon. The most common symptoms are cramping in the abdomen, diarrhea, and weight loss. Other symptoms may include nausea, vomiting or bloating. Some people with Crohn's **disease** have a distinct area of swelling in the abdomen. Some may develop perianal **disease** (**disease** around the **anus**).

Children with Crohn's **disease** may have unexplained fevers, sores around the **anus**, pain or swelling in the joints, or anemia. Some children with Crohn's **disease** may grow more slowly than their peers, and puberty may start late, but they will eventually catch up.

Crohn's **disease** and ulcerative colitis both may cause fatigue, loss of appetite and weight loss.

People with **ulcerative colitis** commonly have bloody diarrhea. They may have abdominal pain and sometimes mild fever. When the rectum is inflamed and in spasm, they may feel rushed to evacuate the **bowel**, though nothing happens. This is called "false urge."

Which Parts of the Body are Involved?

The Digestive System:

Food passes from the mouth down the **esophagus** (swallowing tube) into the **stomach**, which dilutes and mixes the food and passes it on to the **small bowel** (small intestine), which is coiled in the middle of the abdomen.

The small **bowel** absorbs nutrients. It starts at the **duodenum**, which is only a few inches long. It leads into the **jejunum**, which is some three metres long and digests carbohydrates. The **ileum**, about the same length, is the last part of the small intestine, and with the jejunum, breaks down fats. The ileum alone absorbs vitamin B12 and bile salts. (The ileum is a common place for Crohn's **disease** to manifest itself.)

The **large bowel** (also called the colon or large intestine) receives waste from the ileum and absorbs water from the feces, forming stool. The colon is about 1.5 metres long and runs up the right side, across the abdomen, and down the left side to deliver solid stool to the **rectum** for elimination through the **anus**.

What Do We Know About IBD?

No one knows exactly what causes **inflammatory bowel disease**, or why some people have it and others don't.

We know that **bowel disease** is found throughout the world, more extensively in North America and northern Europe; less in central Europe, the Middle East and Australia, and least frequently in Asia and Africa. It is more predominant in temperate than in tropical climates.

There don't seem to be any common characteristics among those who have IBD. Anyone can develop IBD, regardless of gender, race, or age. People are most frequently diagnosed with IBD between the ages of 15 to 25, or 45 to 55.

There is a tendency for children and other relatives of people with IBD to develop these conditions too. This may be for genetic reasons.

Inflammatory bowel disease can be managed through nutritional therapy, medication, surgery, or a combination of these treatments.

Complications of IBD

Potential complications of IBD include malnutrition and malabsorption. Malnutrition is the lack of nutrients provided to the body, and is often simply the result of poor appetite caused by associating food with pain. Malabsorption is the inability of the body to completely absorb certain key nutrients.

Nutritional therapy, which includes a combination of diet, nutritional supplements and "**bowel rest**" is important in the treatment of malnutrition and malabsorption in IBD. For more on this topic, see the next section on Diet and **Inflammatory Bowel Disease**. Detailed information is also provided in the Crohn's and Colitis Foundation of Canada (CCFC) brochure "Nutrition, Diet and **Inflammatory Bowel Disease**."

Inflammatory bowel disease may lead to changes in the intestine itself. People with Crohn's **disease** may have complications such as scarring and narrowing of the ileum, resulting in obstructions in which food becomes blocked and can't pass through the intestine. This may be dangerous and necessitate surgery.

Breaks in the inner lining of the **bowel** may also deepen and develop into "tracts", resulting in abscesses (infected boils) and fistulas (abnormal openings between organs, or from an organ to the skin's surface). Infections may develop, but they can be corrected by antibiotics or surgery.

In ulcerative colitis, the most dangerous complication is toxic megacolon, in which the colon "seizes up" and gases accumulate, causing the colon to swell. If a hole (or perforation) develops in the **bowel** at the same time, the **bowel's** contents, including accumulated bacteria, may leak into the abdominal cavity, causing it to become inflamed (peritonitis). Toxic megacolon can be fatal unless corrected with surgery.

People who have had ulcerative colitis for more than 10 years have a slightly increased risk of developing colon cancer. The risk increases each year after that and therefore, annual diagnostic tests may be recommended.

Fissures (cracks in the skin in the **anus**) and hemorrhoids (swelling of the rectal or anal veins) are common in IBD.

IBD can also lead to complications that don't appear related to the intestine. These "extra intestinal manifestations" may include arthritis, inflammation of joints, or eye **disease**.

Treatments for IBD: Diet, Medication and Surgery

Diet

Everyone needs a balanced diet, but for people with **inflammatory bowel disease** it's particularly important to get a full range of nutrients. IBD can lead to malabsorption; the digestive tract

Some medications taken for IBD may also cause nutrients to be malabsorbed. As a result, the body doesn't digest certain essential vitamins, minerals and elements. The most commonly malabsorbed nutrients are iron, folic acid, calcium and vitamin B12.

People with IBD are also at risk of being underweight and children may also experience delayed growth. Food may be associated with pain and could lead to not eating. People who have Crohn's **disease** may have surgery to remove diseased segments of the ileum, leaving less nutrient-absorbing tissue to process certain vitamins and minerals.

"Eating properly" is the same for everyone: getting half your daily calories from carbohydrates (starch, fibre, simple sugars), the other half from proteins (meat and milk products) and fat (from fish, meat, and dairy products). A dietitian can help those with IBD devise a diet that supplies all the nutrients they need, and suggest

how to compensate for any dietary or nutritional deficiencies they may have.

Sometimes people with IBD may become severely nutritionally deficient. They may need specialized feedings, such as elemental diets (liquid foods, taken orally) or intravenous feedings.

See the CCFC brochure "Nutrition, Diet and **Inflammatory Bowel Disease**" for more information.

Medication

Medications that control **inflammatory bowel disease** include anti-inflammatory drugs (drugs that reduce inflammation); drugs to prevent or reduce various symptoms (such as diarrhea); and drugs that treat complications arising from the **disease**.

Anti-inflammatory drugs include 5-aminosalicylate, glucocorticosteroids and immunosuppressives.

Anti-diarrheal drugs slow the muscles of the intestine, which in turn slow the passage of stool through the body.

Drugs for other complications include antibiotics to treat infections, and medications to compensate for malabsorption of nutrients.

A note about common pain-killers: People with IBD should be careful to avoid taking a common over-the-counter pain-killer for headaches. Acetylsalicylic acid (ASA) can aggravate the symptoms (sores, bleeding) of IBD. If mild pain killers are necessary, acetaminophen may be recommended.

See the CCFC brochure "Medication for **Inflammatory Bowel Disease**" for more information.

Surgery

People with **Crohn's disease** will probably have surgery at some point in their lives. It is not unusual to have surgery to treat abscesses and fistulas. Treating an abscess simply means opening the abscess and allowing fluids to drain. Treating a fistula may mean removing the section of intestine where the fistula has developed.

People with Crohn's **disease** may need surgery to remove an obstruction or blockage of the intestine. Blockages develop when diseased tissue scars and thickens until food can't pass through it. One procedure, strictureplasty, widens the narrowed **bowel**. Another procedure, resection, involves removing the diseased intestine and joining the separated healthy sections.

After surgery for Crohn's **disease**, the **disease** may be inactive for some time, but it may manifest itself again in another part of the gastrointestinal tract.

Surgery is less common in **ulcerative colitis** than in Crohn's **disease**. Emergency surgery is required for toxic megacolon or in cases of extensive bleeding. People who have ulcerative colitis may have surgery to remove the colon, but this is considered only when medication no longer helps, or when the colon becomes cancerous or pre-cancerous.

Surgery completely eliminates ulcerative colitis, but waste is no longer stored or expelled in the usual way. The standard procedure is the conventional end ileostomy. Once performed it means the person cannot control elimination, and must wear an external appliance, or bag, to collect waste. An alternative to this is a procedure in which a pelvic "pouch" is fashioned from existing tissue and inserted into the abdomen to collect waste inside the body. The end of the ileum is attached

to the **anus**, allowing normal **bowel** movements.

See the CCFC brochure "Surgery and **Inflammatory Bowel Disease**" for more information

Medical Terms You're Likely to Hear.

Barium: A liquid taken by the patient that shows the gastrointestinal tract on an x-ray. When the x-ray is of the stomach, the barium is swallowed; this test is called an "upper GI series." When the x-ray is of the lower **bowel**, the barium is administered as an enema. See also Upper GI Series.

Biopsy: A small piece of tissue taken from the body and examined under a microscope for abnormalities.

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CBC (Complete Blood Count): A blood test that evaluates the blood's key components: red and white blood cells, platelets and hemoglobin. The test can determine the effectiveness of medication, and indicate if the person is getting sufficient nutrition.

Colonoscopy: See Endoscopy.

CAT (CT) Scan: This combination of x-ray machine and computer can produce built-up images of the body shown in "slices." In **inflammatory bowel disease**, it's usually the abdomen that is scanned.

Endoscopy: A non-surgical diagnostic procedure, where the doctor views the gastrointestinal tract by inserting a long, narrow fibre-optic instrument into the body. In gastroscopy, the instrument is inserted through the mouth to examine the esophagus, stomach and duodenum. Some people have difficulty swallowing the fibre-optic tube and must be sedated for this procedure. In sigmoidoscopy, the instrument is passed through the **anus** into the rectum and to the sigmoid colon (the last 25 centimetres of the large **bowel**). Sigmoidoscopy may be uncomfortable, but people aren't usually sedated for the procedure. In colonoscopy, the instrument is advanced through the large **bowel** to the cecum (its beginning). Sedation is common with a colonoscopy. Sigmoidoscopy and colonoscopy are also used to perform biopsies and remove polyps (growths).

Enteroclysis (small-bowel enema): An x-ray of the upper intestine in which the person swallows a small tube that is positioned in the upper intestine. The tube is then filled with barium, which shows the intestine in detail on the x-ray.

Gastroscopy: See Endoscopy.

Hemoglobin: A protein present in red blood cells. It carries and releases oxygen to the body tissues. A person with a low concentration of hemoglobin is said to be anemic. See Anemia in the section "Conditions, Symptoms and Complications."

Indium: A radioactive material used in tiny, safe amounts in a blood test (an indium scan) that measures the degree of inflammation of the **bowel**.

Lactose Tolerance Test: Some people with IBD also have lactose intolerance; they don't produce enough of the enzyme lactase, which digests the sugar lactose, contained in milk and milk products. A lactose tolerance test can confirm a lactase deficiency. The patient swallows a test dose of lactose and then blood samples are analyzed. This can also be done using a breath test.

Oral Cholecystogram: An x-ray of the gallbladder taken to check for gallstones. See [Ultrasound](#).

SMA₁₂: A blood test in which one blood sample can be analyzed for 12 biochemical factors.

Ultrasound/Abdominal Ultrasound: A test that uses sound, instead of light, to provide an image of the body. The abdominal ultrasound is a common diagnostic tool for IBD. It provides images of the liver, gallbladder, bile ducts, pancreas, and kidneys. The abdominal ultrasound has mostly replaced the oral cholecystogram.

Upper GI Series: An x-ray of the upper gastrointestinal tract (the esophagus, stomach and duodenum). See [Barium](#) for a description of this procedure. When the x-ray is extended further down into the gut, so that the small intestine is examined as well, that is called an "upper GI series with follow-through examination."

Conditions, Symptoms and Complications of IBD.

Abscess: A painful, pimple-like boil or infection, that can occur around the **anus** or in the abdominal cavity. To relieve it, a surgical incision is made to drain fluids from the abscess. In the case of IBD, abscesses occur only in Crohn's **disease**. See also [Fistula](#).

Anemia/Low Hemoglobin Concentration: A shortage of oxygen-carrying protein in red blood cells. In IBD patients, it is caused by bleeding, destruction of red blood cells, or deficiencies of certain essential nutrients. See also [Folic Acid](#) and [Hemoglobin](#).

Distention: A "distended" or bloated **bowel** is caused when excess gas or liquid accumulates.

Enteritis: An inflammation of the small intestine. If the area called the jejunum is inflamed, it's called jejunitis. If the area affected is the ileum, it's called ileitis.

Excoriation: A scratch or other superficial break in the skin. A person coping with diarrhea can cause an excoriation by frequently wiping the skin of the perianal area, which irritates and damages the skin.

Febrile: Another term for "running a fever." The fever usually indicates inflammation, or infection, or both. The normal oral temperature range is 36 - 37°C.

Fistula: An abscess can lead to a fistula, which is an opening, or connection, between the **bowel** and another organ, where there should not be such an opening. The opening can develop between the **bowel** and other organs, such as another part of the **bowel**, the vagina, the bladder, or the urethra. A fistula can also develop between the **bowel** and the skin. Fistulas occur only in Crohn's **disease**. See also [Abscess](#).

Hemoglobin: See the section Tests for Diagnosing and Tracking IBD.

Hemorrhage: Bleeding from the small or large intestine. Occurs in many patients with IBD.

Obstruction: A blockage of the **bowel** that prevents liquids and solids from passing through naturally. Obstructions can happen when the **bowel** becomes inflamed and scarred, which leads to the **bowel** becoming so thickened that food can't pass through it. This narrowing is called a stricture, and surgery can correct it.

Perforation: An abnormal opening in the wall of the **bowel**. It happens when the wall becomes weak. The contents of the **bowel** can spill into the adjoining

abdominal cavity and cause peritonitis (inflammation), which can be fatal.

Perianal Disease: Irritation or inflammation around the **anus** (the opening from the **bowel** to the outside). This can happen to people with ulcerative colitis, but it is more common in Crohn's **disease**.

Polyp: A growth in the intestine. It can be removed during a colonoscopy. Most are benign, occasionally some are cancerous, others are simply the result of inflammation.

Terms About Nutritional Treatments.

Elemental Diet: A liquid meal containing purified food components. It's given to people who are malnourished to help them gain weight, and because it's an easy-to-digest liquid, it gives the **bowel** "a rest."

Folic Acid/Folate: A vitamin. A person lacking folate is at risk of developing anemia. People can become folate-deficient because of poor diet, or because certain drugs taken for IBD make it difficult for the body to absorb the vitamin. They can compensate by taking oral supplements. People who are deficient in folate are often also found to be deficient in vitamin B₁₂.

Hyperalimentation/Total Parenteral Nutrition (TPN): A feeding technique by which liquid nutrients are delivered using intravenous injection, bypassing the intestine altogether. It is usually done in a hospital. Feeding this way helps the person gain weight, allows the **bowel** to rest, and allows time for inflammation to heal. A few people with Crohn's **disease** may need TPN for a long time.

Lactase: An enzyme that can be added to (or taken before consuming) milk products; it allows people who are lactose-intolerant to digest the milk sugar, lactose. Milk and milk products contain vitamins that are not easily substituted. See also Lactose Intolerance Test.

Nasogastric Feedings: A feeding technique in which a thin flexible tube is passed through the nostril or the mouth and into the stomach.

Surgical Procedures.

Anastomosis: Surgery to join two ends of the **bowel**.

Bypass: Surgery performed on an inflamed **bowel**. The diseased **bowel** is separated from the rest of the **bowel** and may become smaller as a result.

Colectomy: Surgical removal of all or part of the colon. If the rectum is also removed, that is called proctocolectomy. If the rectum is not removed, that is called a subtotal colectomy.

Continent Reservoir Ileostomy: See Ileostomy and Kock Ileostomy.

Ileostomy: When the entire colon is removed, leaving only the small **bowel** to digest food, a new route must be created for food waste to pass out of the body. In a conventional end ileostomy, a surgical opening is made to connect the ileum (the lowermost portion of the small **bowel**) to the skin of the abdomen. An external "appliance," or bag, is fitted onto the body to take over the function of the rectum (collecting and storing stool). The person can't control the elimination of waste material, but can drain the bag whenever it's convenient - usually three or four times a day. There are alternatives to the standard ileostomy which allow the person to control elimination, and allow the wastes to be collected inside the body. See Kock ileostomy and pelvic pouch with ileo-anal anastomosis.

Incision: A surgical cut. In people with Crohn's **Disease**, abscesses (sores) may form in the **bowel**, especially around the **anus**. An incision is made to drain the fluids that collect in the abscess. See [Abscess](#).

Kock Ileostomy: Also called a continent reservoir ileostomy, this is an alternative to the conventional end ileostomy. The Kock ileostomy allows waste to collect in a "pouch" or reservoir of intestinal tissue which has been reshaped to act as a substitute for the rectum; it remains inside the body. A puckered, **artificial** valve, that looks like a navel, acts as a leak-resistant opening from the pouch to the outside of the body. The patient eliminates waste from the pouch by inserting a small tube through the valve, leaning over a toilet, and pouring waste through the tube.

Pelvic Pouch with Ileo-Anal Anastomosis: Developed as an alternative to the standard surgical procedure for ulcerative colitis, the pelvic pouch with ileo-anal anastomosis has become widely used. It involves removing the colon and rectum, but leaving the **anus** intact. A pelvic pouch is created from tissue from the ileum and inserted in the pelvis, to substitute for the rectum. The end of the ileum is attached to the **anus**, which functions normally. There are no external appliances. See [Ileostomy](#) and [Kock Ileostomy](#).

Resection: Surgery in which the diseased portion of the **bowel** is removed and the remaining healthy ends are joined.

Total Proctocolectomy and Ileostomy: In the standard surgical procedure for ulcerative colitis, the colon, rectum and **anus** are removed. The end of the remaining small intestine is connected to the outside of the body where waste is collected and eliminated using **artificial** appliances. Surgery completely eliminates ulcerative colitis. See also [Colectomy](#), [Ileostomy](#), [Kock Ileostomy](#) and [Total Proctocolectomy and Continent Reservoir Bag](#).

Total Proctocolectomy and Continent Reservoir Bag: An alternative to the total proctocolectomy and ileostomy, this procedure makes it possible for the person to avoid having to use an external appliance to collect waste. Instead, a pouch is fashioned out of the remaining intestine to act as a substitute (and still internal) rectum.

The Health-Care Team: Who Does What.

Dietitian: A medical professional who advises people on the nutrition best suited to their medical condition.

Enterostomal Therapist: People with ulcerative colitis who have an ileostomy may have to wear an external appliance in which waste materials are collected. The enterostomal therapist teaches the person how to handle the appliance, and provides counselling on how to adjust to living with the ileostomy.

Family Doctor: A doctor who provides continuing general medical care for the individual and the family.

Gastroenterologist: A doctor with specialized knowledge of the stomach and intestinal tract, including Crohn's **disease** and ulcerative colitis.

Medical Social Worker: A professional who provides insight and assistance with the psychosocial aspects of illness.

Pathologist: A medical specialist who examines biopsies (samples of body tissue) to accurately diagnose **disease**.

Psychologist: A professional specializing in human behaviour.

Radiologist: A medical specialist who performs and interprets the results of x-rays.

Tests performed by a radiologist include the upper G.I. series (upper gastrointestinal series), the enteroclysis, and the barium enema.

Rheumatologist: Some people with Crohn's **disease** or ulcerative colitis may also suffer from pain and stiffness in their joints; others are clearly diagnosed with arthritis. A rheumatologist specializes in diagnosing and treating these inflammations of the joints and muscles.

Surgeon: The medical specialist who performs surgical operations to remove diseased tissue, attach or insert appliances, or remove obstructions.


For further information on this topic, please contact the **Crohn's and Colitis Foundation of Canada** at (416)- 920-5035, or toll free at 1-800-387-1479.

Links to Other Sites

- [Only the Pain is Predictable](#) The Crohn's and Colitis Foundation of Canada
- [IBD, Ulcerative Colitis and Crohn's Disease](#) American College of Gastroenterology
- [Information about Ulcerative Colitis](#) NDDIC Publication
- [Treatment of Ulcerative Colitis](#) NDDIC Publication
- [Ulcerative Colitis Facts](#) NDDIC Publication
- [Crohn's Disease](#) NDDIC Publication
- [Some Facts on Crohn's](#) Crohn's and Colitis Foundation of America
- [Power Points on Crohn's Disease](#) MedecineNet

Patient Information Main Page



Endoscopy Quiz 



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Inflammatory Bowel Disease

Inflammatory bowel disease (IBD) is a term used to describe two similar, yet distinct conditions: Crohn's disease and ulcerative colitis. IBD is also known by other names including: Crohn's colitis, ileitis, distal colitis and pancolitis. These diseases affect the digestive system and cause the intestines to become inflamed, form sores, bleed easily, scar and lose the normal smoothness of their inner lining. Symptoms of IBD include abdominal pain, cramping, fatigue and diarrhea.

Crohn's disease can affect any part of the gastrointestinal tract, from the mouth to the **anus**. Patches of **inflammation** occur, with healthy tissue between diseased areas; these are called "skip lesions". The **inflammation** can extend through every layer of affected bowel tissue. Crohn's disease cannot be cured by drugs or surgery, although either or both can relieve the symptoms.

Ulcerative colitis affects only the colon (large bowel), and only a single layer of bowel tissue: the inner lining. The disease always starts in the portion of the colon called the rectum, and may extend as a continuous (not patchy) **inflammation** from there into the rest of the colon. Usually, ulcerative colitis can be controlled with medication. The disease can be completely eliminated by surgically removing the colon, but afterward, waste material (stool) may have to be stored and expelled through an external appliance.

IBD is unpredictable. Many people experience "flare-ups" (attacks) and then the disease seemingly goes away. The quiet periods are called "remission" and can vary in length from weeks to years. Most people will "relapse" and have multiple attacks. IBD symptoms may also vary in severity. Some people have mild symptoms and can be treated with a combination of drugs and nutritional therapy, while others experience debilitating symptoms and need to take potent drugs, visit hospital frequently, and/or have surgery.

Signs and Symptoms

Since the disease can affect any part of the gastrointestinal tract, people with **Crohn's disease** have very diverse symptoms. Most commonly, the disease

involves the ileum or the colon. The most common symptoms are cramping in the abdomen, diarrhea, and weight loss. Other symptoms may include nausea, vomiting or bloating. Some people with Crohn's disease have a distinct area of swelling in the abdomen. Some may develop perianal disease (disease around the **anus**).

Children with Crohn's disease may have unexplained fevers, sores around the **anus**, pain or swelling in the joints, or anemia. Some children with Crohn's disease may grow more slowly than their peers, and puberty may start late, but they will eventually catch up.

Crohn's disease and ulcerative colitis both may cause fatigue, loss of appetite and weight loss.

People with **ulcerative colitis** commonly have bloody diarrhea. They may have abdominal pain and sometimes mild fever. When the rectum is inflamed and in spasm, they may feel rushed to evacuate the bowel, though nothing happens. This is called "false urge."

Which Parts of the Body are Involved?

The Digestive System:

Food passes from the mouth down the **esophagus** (swallowing tube) into the **stomach**, which dilutes and mixes the food and passes it on to the **small bowel** (small intestine), which is coiled in the middle of the abdomen.

The small bowel absorbs nutrients. It starts at the **duodenum**, which is only a few inches long. It leads into the **jejunum**, which is some three metres long and digests carbohydrates. The **ileum**, about the same length, is the last part of the small intestine, and with the jejunum, breaks down fats. The ileum alone absorbs vitamin B12 and bile salts. (The ileum is a common place for Crohn's disease to manifest itself.)

The **large bowel** (also called the colon or large intestine) receives waste from the ileum and absorbs water from the feces, forming stool. The colon is about 1.5 metres long and runs up the right side, across the abdomen, and down the left side to deliver solid stool to the **rectum** for elimination through the **anus**.

What Do We Know About IBD?

No one knows exactly what causes inflammatory bowel disease, or why some people have it and others don't.

We know that bowel disease is found throughout the world, more extensively in North America and northern Europe; less in central Europe, the Middle East and Australia, and least frequently in Asia and Africa. It is more predominant in temperate than in tropical climates.

There don't seem to be any common characteristics among those who have IBD. Anyone can develop IBD, regardless of gender, race, or age. People are most frequently diagnosed with IBD between the ages of 15 to 25, or 45 to 55.

There is a tendency for children and other relatives of people with IBD to develop these conditions too. This may be for genetic reasons.

Inflammatory bowel disease can be managed through nutritional therapy, medication, surgery, or a combination of these treatments.

Complications of IBD

Potential complications of IBD include malnutrition and malabsorption. Malnutrition is the lack of nutrients provided to the body, and is often simply the result of poor appetite caused by associating food with pain. Malabsorption is the inability of the body to completely absorb certain key nutrients.

Nutritional therapy, which includes a combination of diet, nutritional supplements and "bowel rest" is important in the treatment of malnutrition and malabsorption in IBD. For more on this topic, see the next section on Diet and Inflammatory Bowel Disease. Detailed information is also provided in the Crohn's and Colitis Foundation of Canada (CCFC) brochure "[Nutrition, Diet and Inflammatory Bowel Disease.](#)"

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Breaks in the inner lining of the bowel may also deepen and develop into "tracts", resulting in abscesses (infected boils) and fistulas (abnormal openings between organs, or from an organ to the skin's surface). Infections may develop, but they can be corrected by antibiotics or surgery.

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Surgery

People with **Crohn's disease** will probably have surgery at some point in their lives. It is not unusual to have surgery to treat abscesses and fistulas. Treating an abscess simply means opening the abscess and allowing fluids to drain. Treating a fistula may mean removing the section of intestine where the fistula has developed.

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Enteroclysis (small-bowel enema): An x-ray of the upper intestine in which the person swallows a small tube that is positioned in the upper intestine. The tube is then filled with barium, which shows the intestine in detail on the x-ray.

Gastroscopy: See Endoscopy.

Hemoglobin: A protein present in red blood cells. It carries and releases oxygen to the body tissues. A person with a low concentration of hemoglobin is said to be anemic. See Anemia in the section "Conditions, Symptoms and Complications."

Indium: A radioactive material used in tiny, safe amounts in a blood test (an indium scan) that measures the degree of **inflammation** of the bowel.

Lactose Tolerance Test: Some people with IBD also have lactose intolerance; they don't produce enough of the enzyme lactase, which digests the sugar lactose, contained in milk and milk products. A lactose tolerance test can confirm a lactase deficiency. The patient swallows a test dose of lactose and then blood samples are analyzed. This can also be done using a breath test.

Oral Cholecystogram: An x-ray of the gallbladder taken to check for gallstones.

See Ultrasound.

SMA₁₂: A blood test in which one blood sample can be analyzed for 12 biochemical factors.

Ultrasound/Abdominal Ultrasound: A test that uses sound, instead of light, to provide an image of the body. The abdominal ultrasound is a common diagnostic tool for IBD. It provides images of the liver, gallbladder, bile ducts, pancreas, and kidneys. The abdominal ultrasound has mostly replaced the oral cholecystogram.

Upper GI Series: An x-ray of the upper gastrointestinal tract (the esophagus, stomach and duodenum). See Barium for a description of this procedure. When the x-ray is extended further down into the gut, so that the small intestine is examined as well, that is called an "upper GI series with follow-through examination."

Conditions, Symptoms and Complications of IBD.

Abscess: A painful, pimple-like boil or infection, that can occur around the **anus** or in the abdominal cavity. To relieve it, a surgical incision is made to drain fluids from the abscess. In the case of IBD, abscesses occur only in Crohn's disease. See also Fistula.

Anemia/Low Hemoglobin Concentration: A shortage of oxygen-carrying protein in red blood cells. In IBD patients, it is caused by bleeding, destruction of red blood cells, or deficiencies of certain essential nutrients. See also Folic Acid and Hemoglobin.

Distention: A "distended" or bloated bowel is caused when excess gas or liquid accumulates.

Enteritis: An **inflammation** of the small intestine. If the area called the jejunum is inflamed, it's called jejunitis. If the area affected is the ileum, it's called ileitis.

Excoriation: A scratch or other superficial break in the skin. A person coping with diarrhea can cause an excoriation by frequently wiping the skin of the perianal area, which irritates and damages the skin.

Febrile: Another term for "running a fever." The fever usually indicates **inflammation**, or infection, or both. The normal oral temperature range is 36 - 37°C.

Fistula: An abscess can lead to a fistula, which is an opening, or connection, between the bowel and another organ, where there should not be such an opening. The opening can develop between the bowel and other organs, such as another part of the bowel, the vagina, the bladder, or the urethra. A fistula can also develop between the bowel and the skin. Fistulas occur only in Crohn's disease. See also Abscess.

Hemoglobin: See the section Tests for Diagnosing and Tracking IBD.

Hemorrhage: Bleeding from the small or large intestine. Occurs in many patients with IBD.

Obstruction: A blockage of the bowel that prevents liquids and solids from passing through naturally. Obstructions can happen when the bowel becomes inflamed and scarred, which leads to the bowel becoming so thickened that food can't pass through it. This narrowing is called a stricture, and surgery can correct it.

Perforation: An abnormal opening in the wall of the bowel. It happens when the wall becomes weak. The contents of the bowel can spill into the adjoining abdominal cavity and cause peritonitis (**inflammation**), which can be fatal.

Perianal Disease: Irritation or **inflammation** around the **anus** (the opening from the bowel to the outside). This can happen to people with ulcerative colitis, but it is more common in Crohn's disease.

Polyp: A growth in the intestine. It can be removed during a colonoscopy. Most are benign, occasionally some are cancerous, others are simply the result of **inflammation**.

Terms About Nutritional Treatments.

Elemental Diet: A liquid meal containing purified food components. It's given to people who are malnourished to help them gain weight, and because it's an easy-to-digest liquid, it gives the bowel "a rest."

Folic Acid/Folate: A vitamin. A person lacking folate is at risk of developing anemia. People can become folate-deficient because of poor diet, or because certain drugs taken for IBD make it difficult for the body to absorb the vitamin. They can compensate by taking oral supplements. People who are deficient in folate are often also found to be deficient in vitamin B₁₂.

Hyperalimentation/Total Parenteral Nutrition (TPN): A feeding technique by which liquid nutrients are delivered using intravenous injection, bypassing the intestine altogether. It is usually done in a hospital. Feeding this way helps the person gain weight, allows the bowel to rest, and allows time for **inflammation** to heal. A few people with Crohn's disease may need TPN for a long time.

Lactase: An enzyme that can be added to (or taken before consuming) milk products; it allows people who are lactose-intolerant to digest the milk sugar, lactose. Milk and milk products contain vitamins that are not easily substituted. See also Lactose Intolerance Test.

Nasogastric Feedings: A feeding technique in which a thin flexible tube is passed through the nostril or the mouth and into the stomach.

Surgical Procedures.

Anastomosis: Surgery to join two ends of the bowel.

Bypass: Surgery performed on an inflamed bowel. The diseased bowel is separated from the rest of the bowel and may become smaller as a result.

Colectomy: Surgical removal of all or part of the colon. If the rectum is also removed, that is called proctocolectomy. If the rectum is not removed, that is called a subtotal colectomy.

Continent Reservoir Ileostomy: See Ileostomy and Kock Ileostomy.

Ileostomy: When the entire colon is removed, leaving only the small bowel to digest food, a new route must be created for food waste to pass out of the body. In a conventional end ileostomy, a surgical opening is made to connect the ileum (the lowermost portion of the small bowel) to the skin of the abdomen. An external "appliance," or bag, is fitted onto the body to take over the function of the rectum (collecting and storing stool). The person can't control the elimination of waste material, but can drain the bag whenever it's convenient - usually three or four times a day. There are alternatives to the standard ileostomy which allow the person to control elimination, and allow the wastes to be collected inside the body. See Kock ileostomy and pelvic pouch with ileo-anal anastomosis.

Incision: A surgical cut. In people with Crohn's Disease, abscesses (sores) may form in the bowel, especially around the **anus**. An incision is made to drain the fluids

that collect in the abscess. See [Abscess](#).

Kock Ileostomy: Also called a continent reservoir ileostomy, this is an alternative to the conventional end ileostomy. The Kock ileostomy allows waste to collect in a "pouch" or reservoir of intestinal tissue which has been reshaped to act as a substitute for the rectum; it remains inside the body. A puckered, **artificial** valve, that looks like a navel, acts as a leak-resistant opening from the pouch to the outside of the body. The patient eliminates waste from the pouch by inserting a small tube through the valve, leaning over a toilet, and pouring waste through the tube.

Pelvic Pouch with Ileo-Anal Anastomosis: Developed as an alternative to the standard surgical procedure for ulcerative colitis, the pelvic pouch with ileo-anal anastomosis has become widely used. It involves removing the colon and rectum, but leaving the **anus** intact. A pelvic pouch is created from tissue from the ileum and inserted in the pelvis, to substitute for the rectum. The end of the ileum is attached to the **anus**, which functions normally. There are no external appliances. See [Ileostomy](#) and [Kock Ileostomy](#).

Resection: Surgery in which the diseased portion of the bowel is removed and the remaining healthy ends are joined.

Total Proctocolectomy and Ileostomy: In the standard surgical procedure for ulcerative colitis, the colon, rectum and **anus** are removed. The end of the remaining small intestine is connected to the outside of the body where waste is collected and eliminated using **artificial** appliances. Surgery completely eliminates ulcerative colitis. See also [Colectomy](#), [Ileostomy](#), [Kock Ileostomy](#) and [Total Proctocolectomy and Continent Reservoir Bag](#).

Total Proctocolectomy and Continent Reservoir Bag: An alternative to the total proctocolectomy and ileostomy, this procedure makes it possible for the person to avoid having to use an external appliance to collect waste. Instead, a pouch is fashioned out of the remaining intestine to act as a substitute (and still internal) rectum.

The Health-Care Team: Who Does What.

Dietitian: A medical professional who advises people on the nutrition best suited to their medical condition.

Enterostomal Therapist: People with ulcerative colitis who have an ileostomy may have to wear an external appliance in which waste materials are collected. The enterostomal therapist teaches the person how to handle the appliance, and provides counselling on how to adjust to living with the ileostomy.

Family Doctor: A doctor who provides continuing general medical care for the individual and the family.

Gastroenterologist: A doctor with specialized knowledge of the stomach and intestinal tract, including Crohn's disease and ulcerative colitis.

Medical Social Worker: A professional who provides insight and assistance with the psychosocial aspects of illness.

Pathologist: A medical specialist who examines biopsies (samples of body tissue) to accurately diagnose disease.

Psychologist: A professional specializing in human behaviour.

Radiologist: A medical specialist who performs and interprets the results of x-rays. Tests performed by a radiologist include the upper G.I. series (upper gastrointestinal series), the enteroclysis, and the barium enema.

Rheumatologist: Some people with Crohn's disease or ulcerative colitis may also suffer from pain and stiffness in their joints; others are clearly diagnosed with arthritis. A rheumatologist specializes in diagnosing and treating these inflammations of the joints and muscles.

Surgeon: The medical specialist who performs surgical operations to remove diseased tissue, attach or insert appliances, or remove obstructions.


For further information on this topic, please contact the **Crohn's and Colitis Foundation of Canada** at (416)- 920-5035, or toll free at 1-800-387-1479.

Links to Other Sites

- [Only the Pain is Predictable](#) The Crohn's and Colitis Foundation of Canada
- [IBD, Ulcerative Colitis and Crohn's Disease](#) American College of Gastroenterology
- [Information about Ulcerative Colitis](#) NDDIC Publication
- [Treatment of Ulcerative Colitis](#) NDDIC Publication
- [Ulcerative Colitis Facts](#) NDDIC Publication
- [Crohn's Disease](#) NDDIC Publication
- [Some Facts on Crohn's](#) Crohn's and Colitis Foundation of America
- [Power Points on Crohn's Disease](#) MedecineNet

Patient Information Main Page



Endoscopy Quiz 



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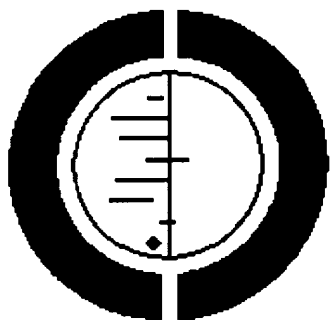
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These search terms have been highlighted: **rectal fistula artificial anus rectum**



Cochrane Incontinence Review Group

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glossary
links

Search Strategy for CENTRAL

CENTRAL on The Cochrane Library (on CDROM)(The Cochrane Collaboration. Oxford: Update Software) is searched regularly.

KEY TO CENTRAL SEARCH STRATEGY: * = wildcard; :ME = MeSH term

The following search strategy was used:

Urinary Incontinence and Enuresis:

- 1.UR INARY-INCONTINENCE*
- 2.I NCONTINENCE-PADS*
- 3.UR ODYNAMICS*:ME
- 4.UR INARY-SPHINCTER-ARTIFICIAL*
- 5.UR INARY-CATHETERIZATION*
- 6.UR INARY-RESERVOIRS-CONTINENT*:ME
- 7.BL ADDER-FISTULA*:ME
- 8.UR INARY-FISTULA*:ME
- 9.TOI LET-TRAINING*
10. VAGINAL-FISTULA*:ME
11. PELVIC-FLOOR*
12. CYSTITIS-INTERSTITIAL*:ME
13. ENURESIS*:ME
14. ENURESIS*
15. BEDWET*
16. BED-WET*
17. (BED near WET*)
18. (DIURNAL near WET*)
19. DIURNAL-WET*
20. (DAYTIME near WET*)
21. (DAY-TIME near WET*)

Contact Us

22. (NIGHTTIME near WET*)
23. (NIGHT-TIME near WET*)
24. (NIGHTIME near WET*)
25. DRIBBL*
26. TOILET*
27. DIAPER*
28. (BLADDER and (SPHINCTER and PROSTHESIS))
29. URODYNAMIC*
30. (CATHETER* near BLADDER)
31. (CATHETER* near INTERMITTENT)
32. (CATHETER* near URIN*)
33. (CATHETER* near INFECT*)
34. (CATHETER* near INDWELLING)
35. (CATHETER* near SUPRAPUBIC)
36. (BLADDER next FUNCTION*)
37. (BLADDER next CONTRACT*)
38. (VOID* next DYNAMIC*)
39. (BLADDER next PRESSURE*)
40. (URETHRA* next PRESSURE*)
41. (URETHRA* next FUNCTION*)
42. (BLADDER next FUNCTION*)
43. (URIN* near SPHINCTER*)
44. (URIN* near PROSTHES*)
45. (URIN* near ENDOPROSTHES*)
46. (URIN* near ENDOPROSTHES*)
47. (BLADDER near SPHINCTER*)
48. (BLADDER near PROSTHES*)
49. (BLADDER near ENDOPROSTHES*)
50. (URETHRA* near SPHINCTER*)
51. (URETHRA* near PROSTHES*)
52. (URETHRA* near ENDOPROSTHES*)
53. (DETRUSOR near SPHINCTER*)
54. (DETRUSOR near PROSTHES*)
55. (DETRUSOR near ENDOPROSTHES*)
56. (DETRUSOR near DYSSYNERG*)
57. (DETRUSOR near HYPERREFLEXIA)
58. (SPINAL next BLADDER)
59. (NEUROGENIC next BLADDER)
60. (NEUROLOGIC* next BLADDER)
61. (NEUROGENIC next BLADDER*)
62. (NEUROLOGIC* next BLADDER*)
63. (NEUROGENIC next VESICAL)
64. (NEUROLOGIC* next VESICAL)
65. (FISTULA* near BLADDER)
66. (FISTULA* near CYSTOCOL*)
67. (FISTULA* near CYSTOVAGINA*)
68. (FISTULA* near VESICOVAGINA*)
69. (FISTULA* near VAGINOVESIC*)
70. (FISTULA* near URETHRA*)
71. (FISTULA* near URIN*)
72. (FISTULA* near VAGINA*)
73. (FISTULA* near COLOVESIC*)
74. (FISTULA* near VESICOCOL*)
75. (FISTULA* near VESICOL*)

76. (FISTULA* near VESIC*)
77. (FISTULA* near URETEROVAGINA*)
78. (FISTULA* near UROGENITAL)
79. (FISTULA* near GENITOURIN*)
80. (PELVIC and FLOOR)
81. (PELVIC next FLOOR)
82. (PELVIS next FLOOR)
83. (PELVIC next DIAPHRAGM)
84. (URINE next EXTRAVASATION)
85. NYCTURIA
86. PERINEOMET*
87. INTERFERENTIAL
88. (INTERSTITIAL next CYSTITIS)
89. (BLADDER next ULCER*)
90. (HUNNER* next ULCER*)
91. DETRUSOR
92. (BLADDER next NECK*)
93. (VESICAL next NECK*)
94. (BLADDER next CERVI*)
95. (CERVIX next VESICA*)
96. (BLADDER next CAPACIT*)
97. (BLADDER next VOLUME*)
98. (VESICAL next CAPCIT*)
99. (VESICAL next VOLUME*)
100. (BLADDER next CONTRACTION*)
101. (NECK next CONTRACTION*)
102. (URIN* near SPASMOLYTIC)
103. (BLADDER near INSTABILITY)
104. (BLADDER near STAB*)
105. (BLADDER near UNSTABLE)
106. (BLADDER near IRRITAB*)
107. (BLADDER near HYPERREFLEXIA)
108. (BLADDER near DYSSYNERG*)
109. (BLADDER near DYSYNERG*)
110. (BLADDER near DYSKINES*)
111. (VESIC* near INSTABILITY)
112. (VESIC* near STAB*)
113. (VESIC* near UNSTABLE*)
114. (VESIC* near IRRITAB*)
115. (VESIC* near HYPERREFLEXIA)
116. (VESIC* near DYSSYNERG*)
117. (VESIC* near DYSYNERG*)
118. (VESIC* near DYSKINES*)
119. (VESIC* near IRRITAT*)
120. (BLADDER near IRRITAT*)
121. CYSTOSTOMY
122. VESICOSTOMY
123. (BLADDER next SURGERY)
124. (BLADDER next RECONSTRUCT*)
125. CYSTECTOMY
126. URETERONEOCYSTOSTOMY
127. (INTRAVESIC* next PRESSURE*)
128. (VESIC* next PRESSURE*)
129. (VESIC* next TENSION*)

130. CYSTOGRAPH*
131. CYSTOURETHROGRAPH*
132. (BLADDER next ASPIRAT*)
133. (BLADDER and PARACENTESIS)
134. (BLADDER next PARACENTESIS)
135. (BLADDER next PUNCTION*)
136. (BLADDER next PUNCTURE*)
137. (BLADDER next DRAIN*)
138. (SUPRAPUBIC next ASPIRAT*)
139. (BLADDER next AUGMENT*)
140. LYODURA
141. URETHROPLAST*
142. URETHROTOM*
143. URETHROCYSTOPEX*
144. URETHROPLAST*
145. (VESIC* next SUPPORT*)
146. (VESIC* next PROSTHES*)
147. (BLADDER next SUPPORT*)
148. (BLADDER near SUPPORT*)
149. (VAGINA* near SUPPORT*)
150. (VAGINA* near PROSTHES*)
151. (BLADDER near TRAIN*)
152. (BLADDER near RETRAIN*)
153. (MARSHALL next MARCHETTI)
154. MMK
155. BURCH
156. (BLADDER near SUSPEN*)
157. (NECK near SUSPEN*)
158. (VESIC* near SUSPEN*)
159. COLPOSUSPENSION*
160. GUITTES
161. COLPORRAPHY
162. COLPORRHAPHY
163. PEREYRA
164. URETHROSUSPENSION*
165. CYSTOPLAST*
166. URETHROPEX*
167. COLPOPERINEOPLAST*
168. URETHROCERVICOPEX*
169. (SLING and PROCEDURE*)
170. (SLING* near PROCEDURE*)
171. STAMEY
172. (PELVI* near REHAB*)
173. RAZ
174. (VOID* near PROMPT*)
175. (VOID* near DIAR*)
176. (URETHRAL next SYNDROME*)
177. (URIN* near LEAK*)
178. BODYWORN*
179. UNDERPAD*
180. (PANT or PANTS)
181. WETTING
182. URIN*
183. (#182 and #33)

184. (#182 and #34)

Faecal incontinence, encopresis and rectal prolapse:

- 1.RE CTAL-PROLAPSE*
- 2.FECAL -INCONTINENCE*
- 3.ANUS
- 4.ANUS *
- 5.RE CTAL-FISTULA*
- 6.C UTANEIOUS-FISTULA*
- 7.ENCOP RESIS*
- 8.DEFE COGRAPHY*
- 9.FECES -IMPACTED*:ME
10. (POLYVIOL and SPONGE*)
11. DEFAECOGRAPH*
12. DEFECOGRAPH*
13. IMPACT* NEAR FECES
14. IMPACT* NEAR FAECES
15. IMPACT* NEAR FECAL
16. IMPACT* NEAR FAECAL
17. IMPACT* NEAR STOOL*
18. (PROLAPSE* near ANO)
19. (PROLAPSE* near ANI)
20. (PROLAPSE* near ANORECT*)
21. (PROLAPSE* near PERIANAL)
22. (PROLAPSE* near **RECTUM**)
23. (PROLAPSE* near **RECTAL**)
24. (PROLAPSE* near RECTI)
25. (PROLAPSE* near MUCOSA*)
26. (PROLAPSE* near PREANAL)
27. (PROLAPSE* near RECTOAN*)
28. (PROLAPSE* near RECTOVAGINA*)
29. (PROLAPSE* near VAGINORECTAL)
30. (PROLAPSE* near ENDORECT*)
31. (PROLAPSE* near VAGINA*)
32. ARCHOPTOSIS
33. (INTUSSUSCEPT* near **RECTUM**)
34. (INTUSSUSCEPT* near **RECTAL**)
35. (INTUSSUSCEPT* near RECTI)
36. (INTUSSUSCEPT* near ENDORECT*)
37. (INTUSSUSCEPT* near RECTOAN*)
38. (INTUSSUSCEPT* near ANORECT*)
39. (INTUSSUSCEPT* near PERIANAL)
40. (INTUSSUSCEPT* near PREANAL)
41. (INTUSSUSCEPT* near ANO)
42. (INTUSSUSCEPT* near ANI)
43. (INTUSSUSCEPT* near **RECTUM**)
44. (INTUSSUSCEPT* near **RECTAL**)
45. (INTUSSUSCEPT* near RECTI)
46. (INTUSSUSCEPT* near ENDORECT*)
47. (INTUSSUSCEPT* near RECTOAN*)
48. (INTUSSUSCEPT* near ANORECT*)
49. (INTUSSUSCEPT* near PERIANAL)
50. (INTUSSUSCEPT* near PREANAL)

51. (INTUSUSCEPT* near ANO)
52. (INTUSUSCEPT* near ANI)
53. (INVAGINAT* near **RECTUM**)
54. (INVAGINAT* near **RECTAL**)
55. (INVAGINAT* near RECTI)
56. (INVAGINAT* near ENDORECT*)
57. (INVAGINAT* near RECTOAN*)
58. (INVAGINAT* near ANORECT*)
59. (INVAGINAT* near PERIANAL)
60. (INVAGINAT* near PREANAL)
61. (INVAGINAT* near ANO)
62. (INVAGINAT* near ANI)
63. PROCIDENTIA
64. (ABDOMINOPERINE* near RESECT*)
65. (ABDOMINOPERINE* near EXTIRPAT*)
66. (MILES* near OPERATION*)
67. (RESECT* near **RECTUM**)
68. (RESECT* near **RECTAL**)
69. (RESECT* near RECTI)
70. (RESECT* near ENDORECT*)
71. (RESECT* near RECTOAN*)
72. (RESECT* near ANORECT*)
73. (RESECT* near PERIANAL)
74. (RESECT* near PREANAL)
75. (RESECT* near ANO)
76. (RESECT* near ANI)
77. (EXTIRPAT* near **RECTUM**)
78. (EXTIRPAT* near **RECTAL**)
79. (EXTIRPAT* near RECTI)
80. (EXTIRPAT* near ENDORECT*)
81. (EXTIRPAT* near RECTOAN*)
82. (EXTIRPAT* near ANORECT*)
83. (EXTIRPAT* near PERIANAL)
84. (EXTIRPAT* near PREANAL)
85. (EXTIRPAT* near ANO)
86. (EXTIRPAT* near ANI)
87. PROCTOPEX*
88. RECTOPEX*
89. (ANOMAL* near **RECTUM**)
90. (ANOMAL* near **RECTAL**)
91. (ANOMAL* near RECTI)
92. (ANOMAL* near ENDORECT*)
93. (ANOMAL* near RECTOAN*)
94. (ANOMAL* near ANORECT*)
95. (ANOMAL* near PERIANAL)
96. (ANOMAL* near PREANAL)
97. (ANOMAL* near ANO)
98. (ANOMAL* near ANI)
99. (MALFORM* near **RECTUM**)
100. (MALFORM* near **RECTAL**)
101. (MALFORM* near RECTI)
102. (MALFORM* near ENDORECT*)
103. (MALFORM* near RECTOAN*)
104. (MALFORM* near ANORECT*)

105. (MALFORM* near PERIANAL)
106. (MALFORM* near PREANAL)
107. (MALFORM* near ANO)
108. (MALFORM* near ANI)
109. (DEFECT* near RECTUM)
110. (DEFECT* near RECTAL)
111. (DEFECT* near RECTI)
112. (DEFECT* near ENDORECT*)
113. (DEFECT* near RECTOAN*)
114. (DEFECT* near ANORECT*)
115. (DEFECT* near PERIANAL)
116. (DEFECT* near PREANAL)
117. (DEFECT* near ANO)
118. (DEFECT* near ANI)
119. (FISTULA* near RECTUM)
120. (FISTULA* near RECTAL)
121. (FISTULA* near RECTI)
122. (FISTULA* near ENDORECT*)
123. (FISTULA* near RECTOAN*)
124. (FISTULA* near ANORECT*)
125. (FISTULA* near PERIANAL)
126. (FISTULA* near PREANAL)
127. (FISTULA* near ANO)
128. (FISTULA* near ANI)
129. (FISTULA* near RECTOVAGINA*)
130. (FISTULA* near VAGINORECTAL)
131. (FISTULA* near VAGINA*)
132. (FISTULA* near SKIN*)
133. (FISTULA* near CUTANEOUS)
134. (FISTULA* near ENTEROCUTANEOUS)
135. (FISTULA* near ENTEROVESIC*)
136. INCONTINEN*
137. CONTINEN*
138. ANAL
139. PROTOCOLECTOM*
140. PROCTOCOLECTOM*
141. RECTOCOLECTOM*
142. (PUDEND* near NEUROPATH*)
143. (PUDEND* near LATENC*)
144. (LORD* near STRETCH*)
145. MEGARECTUM*
146. (TRANSPOSIT* near SPHINCTER*)
147. (EXTERNAL* near SPHINCTER*)
148. (POLYVINYL near ALCOHOL)
149. ANOPLAST*
150. (RECONSTRUCT* near RECTUM)
151. (RECONSTRUCT* near RECTAL)
152. (RECONSTRUCT* near RECTI)
153. (RECONSTRUCT* near ENDORECT*)
154. (RECONSTRUCT* near RECTOAN*)
155. (RECONSTRUCT* near ANORECT*)
156. (RECONSTRUCT* near PERIANAL)
157. (RECONSTRUCT* near PREANAL)
158. (RECONSTRUCT* near ANO)

159. (RECONSTRUCT* near ANI)
160. RIPSTEIN
161. DELORME
162. (WELLS and (((((RECTUM or RECTAL) or RECTI) or ENDORECT*) or RECTOAN*) or ANORECT*)))
163. GRACILOPLAST*
164. (SOAVE near RESECT*)
165. (PERINE* near RESECT*)
166. (ABDOMINOPERINE* near RESECT*)
167. (ABDOMINOPERINE* near EXTIRPAT*)
168. (IVALON near SPONGE*)
169. THIERSCH
170. MUCOSECTOM*
171. MUCUSECTOM*
172. MUCOSALECTOM*
173. MUCOSAECTOM*
174. (ACE near RECTUM)
175. (ACE near RECTAL)
176. (ACE near RECTI)
177. (ACE near ENDORECT*)
178. (ACE near RECTOAN*)
179. (ACE near ANORECT*)
180. (ACE near PERIANAL)
181. (ACE near PREANAL)
182. (ACE near ANO)
183. (ACE near ANI)
184. (ACE near FECAL)
185. (ACE near FAECAL)
186. (ACE near FECES)
187. (ACE near FAECES)
188. (SUPPORT* near RECTUM)
189. (SUPPORT* near RECTAL)
190. (SUPPORT* near RECTI) v(SUPPORT* near ENDORECT*)
191. (SUPPORT* near RECTOAN*)
192. (SUPPORT* near ANORECT*)
193. (SUPPORT* near PERIANAL)
194. (SUPPORT* near PREANAL)
195. (SUPPORT* near ANO)
196. (SUPPORT* near ANI)
197. (SLING* near RECTUM)
198. (SLING* near RECTAL)
199. (SLING* near RECTI)
200. (SLING* near ENDORECT*)
201. (SLING* near RECTOAN*)
202. (SLING* near ANORECT*)
203. (SLING* near PERIANAL)
204. (SLING* near PREANAL)
205. (SLING* near ANO)
206. (SLING* near ANI)
207. LEVATORPLAST*
208. (LEAK* near FECAL)
209. (LEAK* near FAECAL)
210. (LEAK* near FECES)
211. (LEAK* near FAECES)

- 212. (LEAK* near STOOL*)
- 213. (LEAK* near MOTION*)
- 214. NEOSPHINCTER*
- 215. (INTERNAL near SPHINCTER*)
- 216. POSTANAL
- 217. SPHINCTEROPLAST*
- 218. (**ARTIFICIAL** near SPHINCTER*)
- 219. ENCOPRESIS

The topic specific search terms were combined with the boolean operator OR and the contents of the Incontinence Group's specialised register held within the CENTRAL database were removed from the search results using the boolean operator NOT. No terms were used to identify RCTs or CCTs as all the records within CENTRAL are RCTs or CCTs.